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ORIGINAL ARTICLES.

THE LEGAL RESPONSIBILITY OF THE AGED.

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History is replete with the failings of old age. The exceptions are rare and stand out like meteors.

"There is a senile dementia, and a form of dementia associated with general paralysis. Dementia also has its degrees and its stages of *forgetfulness*, irrationality, incomprehension, and inappetency. A patient suffering from dementia, as he passes from bad to worse, *first* exhibits want of memory, then *loss* of reasoning power, then inability to comprehend, and lastly, an abolition of the common instincts and of *volition*.—p. 50, *Field's Medico-Legal Guide*.

In the progress of this mental disorder the mind usually dwells only on the past, and the thoughts succeed one another without any obvious bond of association.

Delusions, if they do exist, are only temporary and leave no permanent impression, and for anything recent the mind is exceedingly weak. If it occurs as *acute dementia* in *young people*, it is generally incurable. In old men, in whom it most frequently occurs, it is called *senile dementia*, and indicates the breaking down of the mental powers in advance of bodily decay. The person may become oblivious of names and dates."

Prof. Geo. M. Beard, now deceased, the great neurologist and electrician of New York city, and author of an elaborate work on these subjects, has divided a paper read before the Medico-Legal Society of New York, into three heads, viz:

1st. What is the average effect of old age on the mental faculties? In other words, what is the law of the relation of age to work?

2d. To what extent is the average responsibility of men impaired by the change which the mental faculties undergo in old age?

3d. How shall the effects of age on the mental faculties be best brought to the attention of our Courts of Justice?

These questions have been a life-long study with this scientist, who set about making his investigations without fear or prejudice, and in the full hope that the result of his researches would be made available in deciding the condition of the minds of men past the full maturity of life.

Dr. Beard has deduced these general results from his prolonged investigations, viz:

The golden decade is	between	30	and	40
The silver	"	"	40	"	50
The iron	"	"	50	"	60
The tin	"	"	60	"	70
The wooden	"	"	70	"	80

He found that seventy per cent. of the work of the world is done before the age of 45. Nearly all the great systems of theology, metaphysics and philosophy are the result of work done between 20 and 50 years of age. And this law holds good in animals and plants as well. Horses live about 25 years, but they are at their best from 8 to 14. Dogs live 9 to 10 years, and are best for hunting purposes from 2 to 6 years. Children born of parents

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healthy in middle life (from 25 to 40 years), are stronger and smarter than those born of parents either younger or older than these extremes; and the same fact applies to the breeding of other animals, as in horses, dogs, and cattle. The hen has her best laying capacity at her third year. She will lay in an average life-time, say nine years, from 500 to 700 eggs. In her first year only 18 eggs; in her second year about 110; in her third 130, the golden period; her ninth year only 10 eggs, if any. In old men the faculties morally deteriorate as do the physical.

This does not necessarily make an old man a bad citizen in the true sense of the term, as of a neighbor or a harm-producing person; but unless sustained by a higher power, he is apt to give a looser rein to his feelings and expressions, to display irritability, less consideration for the feelings of others, and if he has had any variety of brain trouble, this is apt to reflect on his every act.

The diseases to which the brain is liable through a long course of years, are many. Such as blows, destroying the memory of names, dates, locations and events; a bereavement has destroyed the memory of names alone. Millionaires once known for their liberality have grown stingy in old age. Hemorrhage in the brain and the various disorders within the cranial cavity have suddenly or more gradually made the clever foolish, the patient petulent, the hopeful despondent; have caused men, and women too, to change almost *instantaneously* their religious and their political doctrines. When the intellect is impaired by disease of any kind, or by the decay of *age*, men cannot distinguish the true path as of old, even when they desire to do so.

The changes in the brain from old age much resemble a diseased condition, either like the result of hemorrhage from the giving away of the cerebral arteries, from thrombosis, from hardening of the arterial coats, from meningitis, congestion, from anæmia of the brain substance, from nerve tissue decay, and from softening; and death in aged persons is more frequently a process than a sudden event, the process being one of very gradual, incapacitating decline of the mental faculties. An old man may begin to die ten or fifteen years before the absolute death of his body really occurs; and, like a tree, he may die beginning at the top and going down to the trunk. The decline in the moral faculties in old age may be shown in studying the lives of such men as Demosthenes, Cicero, Sylla, Charles V, Louis XIV, Frederick of Prussia, Napoleon, Voltaire, Dr. Samuel Johnson, Oliver Cromwell, Ruskin, Dean Swift, Milton, Lord Bacon, Webster, and Horace Greely. Old men decline in various faculties, some becoming peevish, others avaricious; some mean, filthy and tyrannical; others quarrelsome, sensual, unjust, revengeful, and ungrateful for past favors and kindness.

The best average barometer of mental force is the MEMORY, and decline or any deterioration in the power of the *memory* is the *advance guard* in old age, which sooner or later invalidates the forces of the brain. Most men show their mental powers in middle life, while their advanced years are the periods when they *apply* and *reap* the harvest of the work executed or planned in their palmy days. Thus Lord Bacon, Swift, Dickens, Ruskin, Thackery, Carlisle, Emerson, Wendell Phillips, Graefe, Pinel, Luther, Nelson, Harvey, Webster, Jenner, Jefferson, and Washington did their best work before old age got the better of them. Sterne said that "At sixty years of age the tenement gets fast out of repair"; and Emerson says, in his *Plea for Old Age*, "We cannot count our years until there is nothing else to count," and added, "We postpone our literary work until we find that our literary talent *was* a youthful effervescence which we have now lost." Dr. Oliver Wendell Holmes says: "New ideas build their nests in young brains, and the whisperings of *new truths* are not caught by those who begin to feel the need of an ear-trumpet."

Gen. Halleck in his work on "Military Science and Art," shows that mainly all the successful campaigns of history have been fought by comparatively young men, men in the prime of life, and that most of the early successes of Napoleon were gained over old and worn out generals."

In the late civil war of the States, the North began with old generals, and failure was the result, and the average of the later generals who finished up that contest was between thirty-five and thirty-nine years. We find the average age of the fifty-six Signers of the Declaration of

Independence was between forty and forty-five years.

Mr. Guernsey, of the New York bar, said: "From twenty-five to forty may be considered the *seed time* of life; that is, the time when knowledge is accumulated, and stored up for future use."

There are three causes of moral decline in advanced life:

First. Is the overtasking and overexercise through adult life of the physical and the intellectual faculties, to say nothing of early sexual abuses.

Second. Diseases of the brain, or of other organs, which react on the brain.

Third. Intellectual decline, or the gradual process by which all living beings decay and die.

The question of legal responsibility comes up in old age:

First. As to cases of crime by aged persons.

Second. Cases of wills, which are disputed on the ground of senile incapacity.

Third. When it is desired to fix the limit, as to term of office, etc.

Fourth. As to cases of priority of invention, etc.

Corruption in business and in political life, and breaches of trust are common among the old, as every day's papers inform us. Offenses which depend upon sexual passion are not infrequently among the aged, for it is well known that in the decline of life many return to the vices of their youth. Even clergymen, old men, have been charged with such irregularities.

Cases of Wills contested on the ground of senile incapacity are frequent enough, often giving rise to much trouble and enstrangement among members of the same family; and an evident presumption would often lead to an incapacity to dispose of by will wisely, the accumulated possessions of a life time.

A man in the decline of old age may be irresponsible more or less in one or more directions, while responsible in others. Few men break down all at once merely from decay of powers, but the faculties leave one by one, as one first becomes defective, or softened if of the brain, while the others remain for a while longer fairly healthy. As an army in retreat moves off, some holding their position while other regiments fall back. Thus the wear and tear of an aged person may be rapid, save where money, the touchstone of life, is concerned, for the old man cares rather for the money *in ipso*, than for the good that money can bring. Grudge or personal spite, unnatural enmity against a person, relative or not, often occurs in advanced age, amounting even to more than a disagreeable eccentricity, to almost a disease, and may influence judgement even against those who have been kind and affectionate toward the individual. It is difficult and generally fruitless to endeavor to remove this prejudice.

Then the aged are liable to be deceived by designing persons and have influences exerted over them which in their better day, they would have seen through or have not tolerated. The case of Horace Greeley may be cited as an instance of the irresponsible condition of an old man, he becoming inordinately fond of money as soon as disease invaded his brain, and yet he became insane the last week of his life and his will was disallowed.

When an old man, previously benevolent and wealthy, becomes in dread of the poor-house and begrudges the fuel for his family, the meat on his table, and the clothing for himself and his family, there is reason to suspect very serious cerebral disturbance, which might suffice to incapacitate him for making his will.

An instance may be cited of an aged clergyman, who all his life had been mean and penurious. In his golden decade, in his thirty-fifth year, he had been a minister of the gospel, a noted preacher. Between seventy and eighty he became worse and worse; becoming a geninue nuisance. He lost his memory and his manners; lost his wife; he then married again under the the most absurd circumstances; was then divorced from the wife, and again married. He then went into gross excesses; lost his physical health, which up to that time had been excellent, and finally lost all his money through the treachery of this last wife, who in the end deserted him in his poverty and in his imbecile condition. This man had during all these years made will after will. His friends now took him in charge and treated him as a confirmed imbecile.

Dr. Brigham, of Mass., says that in this country insanity and other forms of brain trouble are three times as prevalent as in

England, and Dr. Winslow, a celebrated expert in insanity, says: "In the incipient stages of cerebral softening, as well as in organic disintegration of the delicate nerve vesicles observed in what is termed progressive, general and cerebral paralysis, ending either in apoplexy or in progressive paresis or in childishness. In such cases the patient often exhibits a debility of the *mind*, of body and of *memory* more *especially long before* the disease of the brain is suspected in regard to the most trifling affairs of his life. He forgets his appointments, or goes to keep them before the appointed time. He is forgetful of the names of his particular friends with whom he has lived in the closest intimacy; he becomes irritable, mislays his book, loses his papers—he sits down to write on some matter of business and his attention being diverted for the moment, he forgets and leaves his letter unfinished."

The *memory* may be considered one of the most delicate tests of the presence of injury or of the progress of natural *mental* decay in the brain. The case is cited of an old man, who could never recollect the names of the inmates of his establishment, recalling *only* the initial letter of each one. He accordingly kept about him a list of their names so as to indicate them.

Old age, wear and tear will, like pressure from a bone on the delicate substance composing the brain, produce more or less complete death of the sentient being for the time. One of the early indications of softening of the brain is seen in the paralysis of the muscles of the face, *i. e.*, the drawing down of the eyelid, and the distortion at the angle of the mouth from paralysis of the corresponding muscles of the other side.

In many instances these irregularities and extravagances are but the premonitory symptoms of softening of the brain, that terrible malady, incurable and which gradually destroys, one by one, the powers of mind and body, and reduces the poor sufferer to a living death. Sensations as of cold, numbness, pain, and of increased warmth at times may all be felt in a perverted state; in some everything touched feels cold; others can bear only the lightest wraps in bed on the coldest nights of winter.

Prof. Simpson, of Edinburgh, knew persons with incipient signs of general *paresis* to complain of their fingers feeling like sausages, cold and fleshy; and it is well known that on the approach of a paroxysm some have had such a feeling about the tips of the fingers as to lead to the habit of biting their nails—and this habit is known to exist in many inmates of insane asylums. The manners in such people are very variable, being different only in that the feeling of numbness and inertia persist and are on the increase all the time with them; while in the adult healthy individual, if this condition comes on at all, it forms a brief attack following generally a recognized cause, and then leaves the party almost, or as well, as before the attack.

It is the opinion of many eminent physicians that there has been a large increase of brain diseases during the present century, and that this increase has occurred in an accelerated ratio in proportion as the strain in commercial and public life of the people has increased, making the struggle for position, for wealth, and even for existence so much more difficult than formerly, when man's ambition was to live simply and to follow the golden rule, thus requiring increasing struggle for the luxuries of life, which finally culminates in cerebral excitement under which the delicately organized brain is forced to yield. Eccentricity is but a name often covering painful afflictions, and any prolonged exaggerated conditions of eccentricity may be said to constitute disease (page 89, work on the Border land of Insanity, by Andrew Wynter, Esq., M. D., of London). Many mental eccentricities are but the *forernuners* of *serious mental* failure. The inability to grasp a stick, the continued numbness of the fingers, the loss of *memory* in small matters, are often indications of serious cerebral disturbance. Dr. Graves, of Dublin, a distinguished physician and writer, cites a case, who could never remember proper names, and Dr. Samuel Johnson, the great English scholar and writer, the author of the beautifully selected passages in Rasselas of the Happy Valley, would attempt in vain to repeat the Lord's prayer in English in his latter days, and yet he could repeat every word of it in Latin.

Dr. Samuel Rogers, the poet, in his later years, showed peculiarities of *memory*,

very like those of persons known to be suffering from disease of the brain; he even forgetting that he had been a poet. This is an uncommon form of loss of memory, for once a poet, a man thinks himself a poet forever. Throughout history from the ancient fathers to our own times, we find like failures for the period of old age. We need only cite the famous John Randolph and that great jurist Samuel Tilden, of New York.

In the bible we read of David and his follies of his old age; of Solomon and his foibles with the fair sex; of the valor to-day, and the cowardice to-morrow of Elijah, in his flight from Mount Carmel; all in the extreme old age; of Moses, the law-giver, who organized the Mosaic Code, finally disappearing and wandering in the mountains lost to memory and to history, so that with all his legal lore he had not the mother wit to keep his bearings, or to leave his final testamentary evidence for future generations.

It has been said in this trial that many cases might be cited in green old age, where great ability and wonderful acumen were maintained even to the day of death. Such cases when seen at all are like angels' visits, few and far between, and "they stand out like meteors in the midnight sky."

Now comes a review of the last great

> "Scene of all
> That attends this strange, eventful history,
> Is second childhood, and *mere* oblivion,—
> Sans teeth, sans eyes, sans taste, sans everything."

And we may add to this doleful picture, sans will, sans memory, and sans care for those who loved him.

See the picture of this poor old man, shrunken; not in his locomotor power alone, but in mind, and failing in his powers of memory, without which the noblest work of the Creator becomes useless, helpless, motionless and reasonless on the tide of life; is at the mercy of the slightest breeze by friend or foe—whichever most caters to his present whims; or like the feather tossed by the stormy waves, it was something once, but wilted and weighted down by the moisture of the sea, it is but a creature of chance. This old man was lame, blind, halt, toothless, and his "voice had fallen in tone from the mighty starboard watch ahoy!" to the childish, feeblest piping and whistling, like the tiny reed; or like the creaking door in his strength, left to rust and droop until no longer with any to care for it, in the end it tilts and falls, carrying danger in its fall. On top of and above all these three-score years and ten, he suffered from the Grippe, that prostrating, debilitating, life-destroying Grippe, which takes its name from the French word "tongs" or "seizings." The French are very *au fait* in their use and application of the proper words. This disease is known to the Italians as "influenza;" to the people of the far south as the "dengue" or break-bone fever, and in England as the "epidemic bronchitis." It is fearful in youth, prostrating to adults and fatal in old age.

In connection with all this disability, lasting many months, this old man attempts to publish his will. Often then he says to his brother and to his elder sister, "Don't you worry; I have *already* provided for you." He thought he had made this provision, no doubt, but on the contrary he *utterly* forgot to mention them. Poor old man! His good intentions took the place of good actions, which he thought performed, until at last he had neither will nor memory, but existed like a plant—simply on the sap that was left and on the light of other days. This honorable jury must forgive him, for he knew not what he did, being irresponsible, and living on the visions, the *ignis fatuus*, of past recollections—merely a creature of habit and repetition.

Thus his constant effort in business was a mere matter of habit and but the shadow remaining of his former good intentions towards those who were justly entitled to his benificence. He did not even recollect the amount of his income, nor did he provide for over one-third of it, and the little he did attempt to will, he divided to those he had foresworn. His *memory* was but a fume, a mist, like the froth on the beer glass—now present like a bubble, and then gone to rise no more.

MISS SOFTLY (who has been attending a course of lectures)—Oh, professor, I saw such a funny old fossil in the museum to-day. I thought of you at once."—*Vogue.*

"You ought to be very proud of your wife. She is a brilliant talker." "You're right there. Why, I could listen to her all night. I often do."—*Texas Siftings.*

PROGRESS OF OTOLOGY.

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It is sad, but nevertheless true, that there are still some physicians who doubt the advance of our knowledge of the diseases of the ear, nor do they appreciate the great changes in the methods of treatment. And this is not to be wondered at, especially among those graduates and physicians who do not read the medical journals nor the new editions of standard medical works. However, we expect better things of men who are looked up to as authorities; leaders in the profession, who have every means of reading, *if they will*, the recent reports and literature on this special subject. Nevertheless such is the case, for great ignorance still exists to this day, as will be believed when we inform you that a young specialist came the other day to consult us about a patient he was treating. After having given directions and compared notes and mentioned the necessary advice, he continued, "I have great difficulty in having certain measures carried out. My orders as a rule are neglected because a relative of the patient, a well-known and leading physician, insists on urging his advice; which is to the effect, 'that the only successful cure of deafness is, in his opinion, syringing with soap and hot water,' and all other means of cure are of little use."

This occurrence is quoted as an example of most frequent experience. Most of my readers are well aware of the value we place upon the use of warm, antiseptic, alkaline solutions in the removal of impacted cerumen; and we always advise and urge their use rather than the employment of mechanical interference, such as the use of the steel or silver probe, spoon, or curette.

No aural instrument should be employed without an accompanying good light; and better than all, as reflected by the head mirror. It will be well just at this place to state, that impacted cerumen is a more frequent cause of deafness than is usually supposed, for in two hundred and fifty cases of diseases of the ear, there were thirty cases in which impacted cerumen, by pressure on the membrana-tympani, caused middle ear disease and impaired conditions with annoying symptoms; yet there are thousands of individuals who have their ears filled more or less with cerumen, which not pressing on the membrana-tympani permits fair hearing and causes no annoyance. Then again we have an army of patients that have diseases complicated or caused by such disorders as we enumerate: Nasal and turbinated bone congestion and obstruction; adenoid growths; naso-pharyngeal catarrh; hypertrophied and inflammed tonsils; scarlatina and measles; tropical effects; also in a reflex manner the menopause, irritation of the auditory meatus, cardiac disease, gout, uterine disorders, syphilis, rheumatism, pregnancy, "morbus Brightii," pneumonia; as also from alcohol, ozena, decayed teeth, quinine poisoning, gun concussion, exostosis of the meatus, catarrhal changes with closed or narrowed Eustachian tubes, perforation of the membrana-tympani, polypus of the tympanum, and disease in the labyrinth (internal ear).

This list shows the general relation of aural to other disorders, and will give a slight idea of the great importance of a correct diagnosis when attempting to treat this peculiar class of symptoms of so much importance to every diagnostician. It is well to have at hand the means of examining the ear with a good silver ear speculum, cotton holder, ear forceps, and above all a good head mirror of short focus, and bright, clear artificial light of oil, gas, or some form of steady electric light. There are many other important instruments for precision, without the use of which a correct diagnosis cannot be made; yet with a speculum and mirror, physicians could often save their patients long and expensive journeys, and spare their own reputation, by first using them carefully to make a diagnosis.

There is a peculiar disease of the external meatus to which we wish to refer as it will at times deceive the most expert. It is termed "desquamative otitis externa," and on inspection resembles the ordinary impacted cerumen so closely that at first sight one is easily misled.

The following is a brief report of an interesting case:

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J. A. T. was brought from the neighborhood of Philadelphia by a friend, who was also a physician, who had been treating him for acute otitis externa (desquamative). The disorder was the result of exposure during a cold night in February, when visiting in the country. The pain complained of was intense and the mental distress was very great, probably for fear of loss of hearing. Our friend had already attended him day and night, and had administered, during the night, two grains of morphine hypodermically, with various local measures which induced but temporary relief. On examination of the right ear, which was quite deaf, the meatus was found swollen and filled up with desquamating macerated epithelium. By aid of the forehead mirror and gaslight, the softened cuticle was removed with the forceps, and the lining membrane of the meatus was so congested in points that it bled at the slightest touch. The membrani-tympani was in the same condition. This was treated locally with hydrochlorate of cocaine ointment, ten per cent. in vaseline. The Eustachian tube was opened with the Politzer air douche, charged with vapor of chloroform. The patient was directed to use internally tincture of aconite, two drops and three drops of tincture of belladonna every hour; also, four grains of sulphate of cinchonidia, with the use of "ungt. hydrag. oxor. flav.," (gr. j to the drachm, and ¼ grain of morphia). This treatment was kept up and in three days all the painful symptoms had disappeared and his hearing was almost restored, without any perforation of the drum membrane or the involvement of the mastoid.

Numerous cases of this class are constantly brought to our notice in the Jefferson College Hospital as well as in private practice, especially during the months of February and March. If the cases are treated continuously they may be promptly relieved. Anodynes, heat and stimulants are all well in their way, but, like pontoon bridges, are only for the emergency which is bridged over with them, and are all to be discarded for the more decided constitutional treatment.

There are also some diseases of the auditory nerve which will be readily understood from the character of the noises in the ear (tinnitus aurium); or as reflex irritation and inflammation from various diseases which cause hemorrhagic inflammation of the cochlea or the labyrinth, particularly in children; primary acute purulent inflammation of the labyrinth resulting from meningitis, much like similar cases caused by syphilitic disease of the labyrinth; traumatism involving the internal ear, later causing atrophy of the labyrinth; changes in the auditory nerve from typhus, scarlet and other fevers, also from variola, diphtheria and mumps. It may also be comprehended how deafness can be an inheritance through a diseased father and mother. Yet the deafness which is charged to this cause is not as frequent as we would be led to suppose by the imperfect statistics of our institutions for the instruction of deaf mutes.

A large number of cases of loss of hearing are developed during the period of childhood when changes in the organs of hearing may occur—the result of colds, dentition, measles, whooping cough, scarlet fever and cerebro-spinal meningitis. The ears are apt to be overlooked in the great anxiety and fight for the life of the child. When the crisis is over then the poor, damaged ear is perhaps examined, only too late and to find the child profoundly deaf. No one can fully appreciate the parents' distress over a deaf child, especially a mute, and but few can understand the importance of hearing both for social intercourse and educational development, until some one near and dear has lost it.

It is an important matter that obstetricians should teach their nurses some knowledge of the anatomy and physiology of the ear, as the deafness of many of the so-called congenital deaf mutes is the result of post natal changes. The meatus of the new-born babe is often filled with a cheesy matter, or it may be blood in the meatus or the tympanic cavity.

Another cause is from neglect to treat in time catarrhal deafness, the result of cold from teething or exposure. The nurse is often at fault for placing the infant in draughts of cold air, and for allowing water to enter the meatus and macerate the membrane, or lodging where it might cause acute inflammation. Pain and persistent earache is often not relieved until nature takes the reins and perforation of the drum membrane takes place with, it might be, subsequent extension to the internal ear and brain if not promptly cared for.

COMMUNICATIONS.

REPORT OF A CASE OF TWO SEPARATE AND DISTINCT UTERI, CENTRALLY SITUATED AND NOT CONNECTED.*

HANNAH T. CROASDALE, M. D.

The patient, aged sixty-three years, mother of three children, was admitted to the Woman's Hospital for treatment for an abdominal tumor.

Twenty years before, she noticed some enlargement of the abdomen, and in five years it reached, she thought, its present dimensions. No discomfort was felt (except from size) until recently, when she experienced pain and pressure symptoms, and the bladder and rectum became very irritable.

The menopause occurred at fifty, and at that time the woman was confined to bed for several weeks, but there was no especial reason given for this, or she forgot just why she was in bed for that length of time.

Her condition on admission was not very good, although no definite trouble could be found except a systolic heart-murmur. Lungs and kidneys were in good condition.

Pelvic examination externally showed a regular enlargement of the abdomen, and there was percussion-dullness from symphysis pubis to umbilicus and almost from crest to crest of the ilia, with a small area of tympany on the left side. The measurements, as noted, are as follows:

From umbilicus to ensiform cartilage, 8½ inches.

From umbilicus to pubic symphysis, 12 inches.

From umbilicus to right anterior superior spinous process of the ilium, 10½ inches.

From umbilicus to left anterior superior spinous process of the ilium, 10½ inches.

On making digital examination *per vaginum* the cervix uteri seemed small, apparently undergone senile atrophy, and it was pushed backward and high in the pelvis, the whole uterus being pushed backward. I thought the fundus looked forward, but the uterine sound did not pass readily, hence its use was not persisted in.

What seemed to be a fluctuating tumor was appreciated *per vaginum* to the right of this uterus and above the brim of the pelvis, and a small, tender mass was felt in the right parametrium. The patient complained of pain and tenderness when touched, especially on the right side.

Diagnosis: Fibro-cystic tumor of, probably, the uterus.

After the usual preparation the patient was etherized and the abdominal cavity opened. On opening the peritoneal cavity the omentum was found to be greatly thickened and congested and extensively attached to the tumor beneath it and to the pelvic walls. It was necessary to ligate and cut in many places, and upon pushing the omentum aside the tumor looked pale and felt and looked like a fluctuating mass. A trocar and canula being used, I was surprised that no fluid flowed through the canula.

The incision was now extended in the abdominal wall upward sufficiently to admit of the withdrawal of the mass entire.

A small nodular mass attached to the lower part of the tumor, having the shape and size of the uterus and being furnished with what seemed to be the uterine appendages, was drawn out of the lower end of the wound and was found to be attached by a small cord-like pedicle to the pelvic brim, a little below the crest of the left ilium.

Another body, to all appearances a uterus with its appendages, was found in the pelvic cavity and fixed by the usual attachments, but had been crowded into Douglas' pouch.

The slender pedicle, not larger than a pencil, which tethered the smaller mass to the pelvic wall was ligated and cut.

The tumor being now freed from its attachments, which were omental entirely, was lifted from its bed. This growth must have derived most, if not all of its nourishment from the establishment of the circulation through the omentum, for it had almost severed its attachment from

* Read before the Philadelphia County Medical Society, January 24, 1894.

other structures, and the omental vessels were enormously enlarged.

The abdominal cavity was cleansed and the opening closed with silkworm sutures, the dressings applied, and the patient was put to bed. Reaction was prompt and good. The temperature for the first four days ranged from 99° F. to 100.4° F. It then rose, and on the sixth day reached 102.6°F., and on the ninth day 105.4°F., when she died of sepsis.

The autopsy showed purulent infiltration at various points in the pelvic cavity. There was also found at autopsy a uterus and appendages in a healthy condition and in the proper position.

Sections from this little body, which hung from the large tumor, were sent to two pathologists. One reported the specimen as being that of the structure of a fibro-myoma. The other pronounced it uterine tissue, and some structure resembling the endometrium.

If this is a separate and distinct uterus, and I think it is, it is an unusual case, a unique case.

We know that bodies which are not properly situated are not well organized, and take on disease very readily. This second uterus had developed from its *cervix* a fibro-myoma. As it grew too large for the pelvic cavity and rose above the brim, the little organ was inverted and so hung suspended from it.

It measures from the internal os to the fundus one and one-quarter inches. The length and size of the cervical portion is exaggerated, evidently from the tension upon it, but as it was cut open in the fresh state it showed quite distinctly the arbor vitæ arrangement of the mucous membrane lining the canal, and the lips and cervical canal were quite natural in appearance. The os internum on the left side admits the passage of a small probe, which passes a little distance along the Fallopian tube. On the opposite side the opening would not admit of the passage of the probe. There are two small ovaries which, on being cut open, showed on macroscopic inspection ovarian tissue. No microscopic examination of this tissue has been made. In the cervical canal, just below the internal os, is a small calcareous deposit.

The didelphic uterus we have seen, and these cases are actually two uteri, separated as far as the cervix and including it, and not two bodies more or less divergent, as in the case of the uterus bicornis. Ollivier's specimen of a uterus didelphys, and divided vagina with a distinct cervix uteri looking each into its own vagina, was taken from a woman who had been pregnant five times. Each segment presented the appearance of a complete uterus, seeming to be two unicorn uteri equally developed and apposed without fusion.

It used to be thought that this malformation occurred only in nonviable embryos with deformities of other organs. It has been seen with ectropian of the bladder, with imperforate anus, and other malformations. But an entire organ, far removed from one in the usual location, I have not seen mentioned.

CALCIFIED CORPORA LUTEA.

Another specimen is this little body which I at first thought was a lithopædion, but, seeing Bland Sutton's note on calcified corpora lutea, find it to correspond very closely with the description of two specimens which had been sent to him at about the same time. He considered them very rare pathological specimens. Dr. Voelcker secured one from an ovary of a woman who died of mammary cancer very widely disseminated, and he supposed the two little nodules in the ovary to be secondary deposits; but cutting into them found them to be concretions. One was encysted and had outwardly the appearance of a mulberry calculus of the bladder, the other was imbedded in the ovarian tissue and was of irregular shape.

When this specimen was fresh it was of a bright-yellow color, very characteristic of a recent corpus luteum. It cut as would wax, perhaps of firmer consistence.

Those specimens which Bland Sutton describes consisted of dense tissue impregnated with lime salts. Mr. W. A. Meredith speaks of examining a patient and distinctly feeling the hard body through the vagina, and it gave rise to the impression that the swelling might be the sac of an ectopic gestation containing fragments of bone.

Dr. Coe, of New York, recently described a similar body under the impression that it was a bony nodule.

A CASE OF ERYSIPELAS.*

P. GUNTERMANN, M. D., Louisville, Ky.

Since erysipelas is strictly considered a surgical disease, I do not propose to discuss at length what does not seem to properly belong to the domain of the general practitioner, though he may have to deal with it quite as often as the surgeon. Yet, in order to excuse the report of an every-day occurrence, it becomes necessary to at least make a resume of the leading features then my case may seem to be *apropos*.

We know what erysipelas is. It is an infectious disease manifested by more or less dermatitis, inflammation of the mucous surfaces and also of the serous membranes. It is claimed, and I think justly so, that the first requisite is a wound, ever so small, through which the system becomes infected. The infecting agent is the "erysipelas coccus." That it is a disease communicable from one individual to another, from man to beast and *vice versa*. If it bears a close similarity, not to say, relationship, to other dermatites or erythema nodosum, eczema, etc. The positive differentiation is in the presence of the *erysipelas coccus* found in the blood, the tissues, etc., of the patient.

Erysipelas is conventionally classified E. simple, E. migrans, (fugax); E. nodosum, and E. gangrenosum.

The cause of erysipelas then is, first, a wound, and, second, the coccus erysipelas, a bacterium.

The symptoms, as a rule, are pronounced. It is ushered in with chilliness, a chill, or rigor more or less severe and prolonged. Soon fever sets in, and in most cases the temperature runs high and remains so until the disease abates. The skin is hot and dry, the tongue brown, parched and cracked. Often we have delirium and prostration, always if the disease is protracted.

The local signs make their appearance at the site of injury and infection; we have itching, redness, heat, pain and swelling. The intensity of all these depends on the individuality of the patient.

Erysipelas is more severe in old and debilitated people and those who have a peculiar disposition. There are persons who have this predisposition. The intensity also determines by which of the four varieties we will name the case on hand.

The diagnosis is comparatively easy and seldom, I dare say, are mistakes made in this direction.

The prognosis is nearly always favorable except in the pueperal state—very often fatal—and in the feeble and debilitated, or when complicated by other disorders particularly of the kidneys and contents of the cranium. Nephritic troubles are rather frequent complications.

The treatment is general and local. The systemic treatment consists in sustaining, stimulating foods and medicines, and antipyretics and tonics, occasionally anodynes, etc. Locally we use the different antiseptics in their different forms.

Prophylaxis is easy and ought never to be neglected but very strictly carried out. The patient ought to be especially cautioned to prevent relapses.

It may not be amiss to mention that the erysipelas bacterium has been successfully used in bringing on the disease artificially, for the cure of cancerous disease. It is a mooted question whether the cure is the result of nutritive changes or whether the cancer cells are directly destroyed by the new intruder.

The report of the following case shows in my estimation, all phases of erysipelas.

Mrs. P. is sixty-six years old, is thin and of wiry frame. She is the mother of nineteen (consecutive) children. Has always been well until the climacteric period at about forty-nine or fifty years. Since that time she has had 4 or 5 distinct and severe attacks of erysipelas. The last before this one was of exceptional gravity. The disease traveled all over her body and general septic trouble set in, attended and followed by a number of abscesses. Finally she recovered and was quite herself again until the present attack.

Patient in attending to her feet had wounded the big toe of the left foot. A few days later she became aware of the

*Read at a meeting of the Louisville Clinical Society January 2, 1894.

presence of the old enemy. On the 24th, day of November, 1893, a doctor was called who diagnosed erysipelas, prescribed and did not return. I saw patient for the first time on Nov. 28th, and thence almost daily, making my last visit Dec. 31st, 1893.

This was the patient's condition: High fever, temperature 104° to 105° F.; pulse 140; skin dry and harsh; tongue brown and cracked; great irritability and slight wandering; bowels and kidneys acted fairly well; the left foot and leg were enormously swollen, covered with large blisters, the contents of which were saneous, opaque and the surface underneath slightly granular tending to suppuration; a gangrenous patch at the inner malleolus, and the toe nails ready to drop. This part of the patient's anatomy had to bear the brunt of the infection.

From the knee up the disease migrated by daily making new invasions of the healthy skin. Up the thigh, over the back of the neck, down the left arm, up the neck over the hairy scalp and over the face, down the right arm, breast, abdomen and right thigh. So far the new invasion could be called *simple*. In the right leg and foot the swelling became very great, rivaling its companion. The constitutional changes became alarming. However the patient rallied, the local trouble subsided and she is convalescent.

The treatment consisted in liberal stimulation, light, nourishing food, large doses of quinine and tinct. ferric chloride. Locally I used a dry antiseptic powder covered by boric cotton. I always prefer dry applications, in this case, particularly, on account of the extent of the disease and the discharge from the numerous denuded surfaces.

A COMPLICATED COLLES' FRACTURE.

E. J. KEMPF, M. D., JASPER, IND.

Mr. C. A. brought his seven-year-old girl to my office in January, 1894, accompanied by his wife. They said the little girl, on her way home from school, had fallen from a fence on her hands and had broken one of her arms. It was now two hours since the accident had happened; they had first called upon Dr. S—— but he was not at home.

I found the left arm of the little girl in a very curious shape. There was a green-stick fracture of the ulna near its upper third, and a Colles' fracture of the radius near the epiphyseal line. A good description of it would be a silver-fork deformity with the handle twisted.

The arm was pronated to the extreme, and could not be turned or supinated. The long axis of the arm was decidedly shortened. The ulna being partly broken (green-stick) at its upper third and bent outward, and the radius being broken at the epiphyseal line, it seemed to me as if one fracture wedged the other.

I explained the fractures to the parents of the child, and advised them to call in Dr. Brannock in consultation and to assist in the reduction of the fractures. This the parents would not consent to. I then explained to them the wedging of the two fractures, one by the other, and that I would have to give the child chloroform or ether, and that I thought it more than likely that one doctor would have to bend back the broken ulna, whilst the other doctor made counter-extension and extension in order to reduce the Colles' fracture of the radius. Furthermore, that a Colles' fracture was always a serious one; that it was sometimes followed by deformity and stiffness of the wrist, no matter how carefully it was reduced and treated; that this particular arm was fractured in a peculiar and unusual manner; that I had never seen one just like it, that I had never read of one just like it, and that it was possible that I was mistaken in my diagnosis of the fracture.

The mother was a child of the forest, or backwoods, and a great believer in *Natur'*. She could "not for the world see" why I made such "a great a-do" about the matter, and said, "Why, doctor! can't you fix it up?"

I answered, "What do you mean by that?"

"Why, get some shingles and tie it up. It'll come out all right. She's young, and she'll outgrow it; and if it is a little crooked, that won't hurt. I know my sister had her arm broken years ago, and never had no doctor at all, and it got all right. It's a little crooked, but she can use it and don't mind it. And my neighbor's boy had it's arm broken, and a doctor set it, and it was right crooked; but he don't mind it any more, and he can use it. Fix up the arm, doctor."

I then appealed to the father, but all he had to say was, "I've got nothing to say at all—at all."

So I picked up my hat and went after Dr. Brannock.

The doctor examined the arm and concurred with my diagnosis. He also insisted that the child be given chloroform, so that the fracture could be properly reduced without giving the child too much pain. But the parents were obstinate, and would not agree to the chloroform.

We now made two propositions to the parents. One was, that they go somewhere else to have the child treated; the other, that we reduce the fracture as well as we could, and that if any untoward deformity occurred, that they take the blame.

They eagerly accepted the latter proposition.

Accordingly I clasped the fingers of the child's hand into my fingers and made forcible extension of the wrist, at the same time I pressed the fragment of the broken radius down into the position; whilst Dr. Brannock took hold of the forearm, with his fingers above and below the fractured point of the ulna, and with his thumbs forced the ulna into a straight line. We used considerable force, but we accomplished our purpose quickly. Whether the lower fragment of the Colles' fracture was completely reduced we could not tell, because the limb was now very much swollen and very painful, and the parents would not allow further manipulation.

After reduction of the fracture, we placed the hand in flexion on a Levis' metallic splint, and bandaged up the arm.

In four days the mother brought the child to my office and I found the arm in good condition. I instructed her to come back in a few days again, or sooner if there was much pain or swelling.

The patient never came back, and what the outcome of the matter is I do not know.

Remarks: I have given a history of this case just as it occurred, and now I call attention to a few lessons to be derived therefrom.

First. There seems to be an idea among non-medical people that to fix up a fracture consists in putting the limb into some apparatus and then bandaging it up. Whilst this is a very important factor in the proper and successful treatment of fractures, the first and most essential point is the *proper reduction of the broken bone.* If the broken bone is not well reduced, deformity is bound to occur.

Second. There are some people who believe that if a doctor has once handled a broken limb and bandaged it up, the after-treatment is of no consequence. Case after case could I relate as having occurred in practice, that I never saw after the first handling of the broken limb.

Third. There are some people who are insanely afraid of an anæsthetic, just as there are some who have a holy terror against vaccination, against calomel, against quinine, against baths, etc. And if you trace this mania to the root, you will always find it due to the foolish talk of some doctor who had more tongue than brains.

Fourth. If a doctor meets with a case of fracture where the patient himself, or those who are in authority over him, refuse to comply implicitly with the suggestions of the doctor, let him at once either refuse to treat the case, or insist on having a consultation with some other responsible surgeon or physician. If then a suit for malpractice does come up, the attending physician will have a witness worth a ton or two of medical expertism.

Fifth. Was it my duty to hunt up the case after the patient failed to come to my office or send me word is a question that I could only answer, "Yes, for my own protection" had there not been a consultant at the first visit, who was acquainted with all the circumstances.

"Well, what did your wife give you for Christmas?"

"Why, it was a—er let me see, a very fine—ah—dear me! I can't remember just what it is but I know it is very becoming to her.—*Washington Star.*

A NEW METHOD OF EXAMINING THE KIDNEY, ESPECIALLY FOR STONE.*

CHARLES P. NOBLE, M. D.†

I desire to report a short history of the following case, together with an exploratory operation which I performed to enable me to examine her kidney, including the pelvis of the kidney and perhaps one inch of the ureter.

Mrs. T. S., aged thirty-seven years, mother of three children, enjoyed good health until six years ago. Since that time she has been more or less an invalid, unable to attend to her duties. The prominent points in the history are that she has had three well-marked attacks of hæmaturia accompanied by violent renal colic (so-called) and that, at least twice, she has passed good-sized stones, the last one coming from the left kidney. In addition to this history of violent seizures of renal colic, she has suffered frequently with milder attacks of paroxysmal pain referred to the region of the right groin, the pain being, perhaps, most acute just above the right trochanter major. Recently these attacks have been of daily occurrence, and have been brought on when she was on her feet. She is, usually, but not always, comfortable when in bed, but shortly after any attempts at walking the pain comes on. The sexual organs are normal, with the exception of a trifling tear in the perineum. The urine has been examined many times and has a very uniform composition. Its specific gravity has varied between 1020, 1013 and 1018; it is acid, and contains pus, bladder epithelium, and ureteral epithelium, but none from the pelvis of the kidney. The urine from each kidney has been examined separately—the urine being obtained by means of the ureteral catheter. Examined in this way it has been found that the urine from each kidney is much the same, the pathological elements it contains being somewhat more marked on the right side. This difference, however, was distinctly marked with reference to the two sides. The urine from the left kidney has always flowed through the ureteral catheter freely and regularly; that from the right kidney has not done so. Upon two occasions the ureteral catheter remained in position upward of twenty minutes, and not more than one or two drops of urine flowed out. Upon another occasion, after waiting thirty minutes with the same result, suddenly one hundred and twenty minims poured out.

Taking all the facts of the case into consideration the conclusion seemed fair that there was a stone in the right ureter, and that probably this was in the pelvis of the right kidney. Several attempts were made, both by Dr. Howard A. Kelly and myself, to pass a ureteral sound along the ureter toward the kidney. It was not possible to make the sound reach above the brim of the pelvis. It was therefore proposed that an incision be made in the loin for the purpose of examining the kidney and the upper portion of the ureter from above.

My experience in performing nephrorrhaphy for movable kidney after the technique of Dr. Edebohls, has taught me the facility with which *a movable kidney* can be drawn out through an incision in the loin. So far as I know, no one has ever treated a non-movable kidney in this way. It occurred to me it might be feasible, and that at all events an attempt judiciously made could hardly be a source of danger.

Accordingly on December 12th, I made the usual incision in the loin down to and through the peri-renal fat, exposing the lower end of the kidney. With the index finger the kidney was then separated from its connective tissue attachments and gradually drawn down into and out through the wound, so that it was entirely outside. It is now a very simple matter to explore the kidney by thumb and finger pressure, and to make certain that it was in a normal condition. It was equally easy to examine the pelvis of the kidney, and to determine that this contained no stone. Perhaps one inch of the ureter also was within reach.

As nothing abnormal could be felt, the kidney was replaced within the abdomen and the incision was sutured in the usual

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way—buried silkworm-gut sutures being placed in the muscular layer, and superficial silkworm gut sutures in the skin. No unfavorable reaction followed this operation, and so far as the operation itself was concerned the patient made an uninterrupted recovery. Unfortunately the operation had produced no effect whatever on the symptoms, which are the same now as before it was done.

I report the case simply to bring before you this method of examining the kidney. From my experience in this case and in cases of movable kidney, I believe it will be a simple and safe matter in the hands of a skilful surgeon who has had some experience in kidney work, to remove through an incision in the loin all non-suppurating kidneys having approximately the normal size, for the purpose of a careful examination. The procedure is certainly not one of much gravity, and when done under the conditions laid down should have no mortality. Tentatively I would recommend the adoption of this method of exploring the kidney whenever the symptoms point to the presence of stone in the kidney or its pelvis, and when these symptoms are of sufficient gravity to invalid the patient. I feel confident that as compared with the ordinary method of exploring the kidney through the depths of the incision in the loin, the kidney itself being largely or wholly above the level of the ribs, and imperfectly palpated because of its movability, or examined by means of a puncture with an exploring needle, that there can be no question of the superiority of the method proposed and herewith reported.

Upon theoretical grounds this procedure would not be applicable in cases of abscess of the kidney. Under these conditions, supposedly the kidney would be fixed and not easily separated from its connective tissue bed. Moreover, it would be enlarged, and in addition to this there would be the risk of rupturing the pus sac, perhaps inadvertently into the peritoneal cavity.

TRANSLATIONS.*

THE INFLUENCE OF INTERSTITIAL INJECTIONS OF SALICYLATE OF MERCURY UPON THE EXCHANGE AND ASSIMILATION OF NITROGENOUS MATERIALS FROM A QUANTITATIVE AND QUALITATIVE STUDY IN SYPHILITICS.

P. Froloff, of Saint Petersburg, (*Le Progrès Medical*, August 12, 1893), remarks that the views of writers upon the influence of mercury upon the metamorphosis of nitrogenous materials in syphilitics are very various. According to Güntz and Liégeois the interchange is increased, while according to Boëck and Hallopeau, mercury has not any influence upon the exchange within the organism and the production of urea. Lépine and Rémond believe, on the contrary, that mercurial frictions dimish the quantity of nitrogenous compounds in the urine. The same view was held by Stepanoff, Vajda and Rambach, whose works were published in 1875–76.

All of the observations, the number of which is insufficient, do not agree with the conditions laid down by Voit, since all the authors quoted, with the exception of Boëck, have studied the exchange without determining the quantity of nitrogen introduced with the food and eliminated with the alvine dejections.

Noticing this diversity of opinion upon a question of so great importance, and the almost universal defect in the studies upon the subject, Froloff has made a study of the assimilation and exchange of nitrogenous materials in syphilitics under the influence of the mercurial treatment. He selected from the other modes of treatment the introduction of mercury into the organism by interstitial injections of the salicylate of mercury in suspension in liquid vaseline. In the course of his work,

* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators W. A. N. Dorland, M. D., M. B. Werner, M. D., and F. H. Pritchard, M. D.

when the greatest part of his experiments were already completed, appeared the thesis of Dr. Jakovleff, "Upon the Metamorphosis of Nitrogenous Substances in Syphilitics during the Primary Eruption." In this, he observed that results almost identical with his, were obtained in patients submitted to the mercurial treatment by entirely diverse methods. A portion of his conclusions were absolutely analogous to the conclusions of the author cited. Jakovleff chose his patients among recent syphilitics during the recent incubation, and at the commencement of the eruption. In three cases the author had observed the patients without treatment; in three cases the patients were submitted to frictions at the onset of the roseola, and finally in one case, daily subcutaneous injections of the bichloride of mercury were employed. Basing his views upon these severe cases observed closely and for some time, the author has arrived at the following conclusions: 1. The exchange of nitrogen in the period of the first eruption considerably increased, notwithstanding that the temperature remains normal. From a qualitative point of view, the exchange falls. 2. The assimilation of nitrogen from the food diminishes in the same period. 3. Under the influence of mercurial frictions the assimilation of nitrogen is notably improved, the exchange diminished and oxidation increased.

Froloff has studied his cases, not only during the period of the primary eruption, but also during the secondaries. The last experiments were undertaken in the hope that in the secondaries the effects of the mercurial medication would be cleaner, and could be more easily differentiated from the effects of the disease itself. In all he had observed, eleven cases, six of which were syphilitic, with the secondary manifestations and the condylomatous period, and five with the early forms of the primary eruptions. Two patients in the first group were submitted to injections of pure liquid vaseline. One of the patients of the second group was also submitted to injections of pure liquid vaseline during the whole duration of the observation. Each experiment had a duration of from twelve to fifteen days, and was composed of four to five periods of three days, without counting the time necessary to cause a state of equilibrium. The patients were held a fixed regimen. Oxidation was made according to the method of Kjeldal. The quantity of nitrogen in the feces and urine was determined daily by the volumetric method in the apparatus of Borodine. Moreover, each day, in the same manner the quantity of nitrogen in the urea and extractives was determined by the method of Lépine and the uric acid according to the method of Haykraft. The presence of mercury in the urine was determined by the method of Votz. The following conclusions were reached: 1. The injection of salicylate of mercury in suspension produced in syphilitics with the relapsing forms, an increase in the exchange; this increase is sometimes very marked; while during the injections of pure vaseline, which of itself seem to have no action, the exchange fell. 2. From the qualitative point of view the exchange was most complete. 3. The assimilation of nitrogen diminished a little in the same patients. 4. It was noticed in the patients with the recent forms, in whom the exchange was greatly increased, that under the influence of the injections, the exchange of nitrogen fell with diminution in the urine of the products of incomplete oxidation, and the assimilation improved. —W.

COCAINE IN OTITIS MEDIA (Acute).

Wolfstein recommends cocaine in middle ear disease. He claims it to be an abortive, a preventive against suppuration, and an anodyne. The modus operandi is as follows: Instil into external meatus five to six drops of a five per cent. solution of hydrochlorate of cocaine. Pain disappears in from ten to fifteen minutes. Repeat if necessary. Two to three days treatment consisting of four to five instillations daily are sufficient to cure. In very severe cases repeat this treatment daily, and if necessary use an eight or ten per cent. solution.—*Allg. Med. Central Ztg.* —M.

PROSTATITIS.

Ullman recommends following:

℞ Ichthyol.....gr. viiss (0.5).
Extr. Belladonnæ.....gr. ii (0.15).
Butyr. cacao.....3iv (15.0).
Met. ft. suppos. No. x.

SIG.—Use once or twice daily after evacuation of bowel.

—*Memorabilien.* —M.

SUPPURATION OF OVARIAN CYST AFTER TYPHOID FEVER.

Prof. Werth (Kiel) removed a dermoid cyst which was suppurating. Typhoid bacilli were found in pure culture. The patient had typhoid fever from October to November, 1891, and applied for treatmenton June 2, 1892, to Dr. Werth, on account of abdominal swelling and pain.

On opening the abdomen the cyst wall tore, showing very thin pus, sebaceous matter and short, thin hair. The cystic fluid showed under the microscope few leucocytes and considerable detritus. No bacteriæ were found. The contents of the cyst were introduced into gelatine, showing, after a few days, pure cultures of the bacillus of typhoid fever.—*Deutsche Med. Wochenschrift.* —M.

TREATMENT OF AMENORRHŒA.

Dr. D. Labbé (Paris) reports three cases treated with the negative pole (cathode) of a constant current. The positive electrode is applied on the lower part of the abdomen in the linea alba. Applications did not exceed 5 minutes at a time. The intensity of the current was never more than 50 milliamperes. Instruments used should be made aseptic and in all cases the operator should convince himself that the uterus is empty.—*Jour. de Médicine de Paris.* —M.

THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.

CORNUTINE DURING THE PUERPERIUM.

Dr. Krohle (*Il Raccoglitore Medico*, No. 16, 1893) thinks that cornutine, which Kobert holds to be the true active principle of ergot, if administered during the puerperium exerts a favorable influence upon the uterine involution. He uses the following formula:

℞ Cornutine.....3 cgms. (gr. ½).
Potter's clay.....3 gms. (grs. xlv).
Water.
Glycerine, ana..... q. s.
Sufficient for twenty pills. Six pills per diem.

It is indicated after extraction of the placenta and the membranous residua after abortions. In cases of sub-involution, or where the lochia remain a long time sanguinolent in puerperal endometritis, and, finally, after normal labor to hasten restoration to the normal condition. It is, on the contrary, contra-indicated in hemorrhages during pregnancy and, in weak contractions during the period of dilatation and expulsion.

PHENOCOLL IN MALARIC ENLARGEMENT OF THE SPLEEN.

Prof. Cervello (*Il Raccoglitore Medico* No. 1, 1893) of the University of Palermo, in a monagraph on phenocoll, asserts that he has observed a notable retraction in size, of the malaric spleen in patients under his care. It is peculiar that other observers have not noticed this. Dr. E. Michell, also claims the same results. He employs intra-splenic injections of a saturated solution, and though it was used but a short time, and in only two subjects, a remarkable reduction was observed in a short time. With this reduction there was also an improvement of the local and general symptoms. The number of red-blood corpuscles was increased over one-third.

FOREIGN BODIES IN THE ŒSOPHAGUS.

Dr. Ott (*Der Aerztliche Praktjker*, No. 48, 1893,) was consulted by a patient, who, eight years previously, had swallowed a piece of glass. A sound was introduced into the œsophagus, and came in contact with a hard body, at a level with the head of the sternum, which was apparently fixed in the anterior wall of the œsophagus. An attempt at extraction with a long and curved forceps did not succeed. He had no other instrument so that he was obliged to improvise the following: He took a new and very compact sponge and cut a piece out, the shape of a nine

pin, one inch and a half in length and three-quarters in breadth at the base. It was then perforated with a trocar, an urethral bougie pushed through this opening, and carefully tied to the sponge. Besides that he fastened a long thread to the sponge in order to be able to withdraw it in case that the bougie should break. The sponge-tipped bougie was then pushed down below the fragment, and in a few minutes the sponge had swollen so that it filled the entire œsophagus. It was then slowly withdrawn and with it the splinter of glass. Hemorrhage was quite severe, but it yielded to swallows of ice water.

PHENACETINE IN INTERMITTENT FEVER.

Dr. Bernheim (*Il. Raccoglitore Medico*, No. 12, 1893,) claims that phenacetine is capable, like the sulphate of quinine, of suppressing the attacks of intermittent fever, if only it be administered in the proper doses and at the right time. Its action is manifest after an hour, reaching its maximum in two hours and ceasing in five to six hours. Hence it follows that it is best given from two to three hours before the onset of the attack. A dose of one gram (fifteen grains) is preferably given at first, and in obstinate cases, one-half to one grams (seven-and-a-half to fifteen grains) two hours before. No inconvenient or disagreeable results were observed. The lowest temperature is not obtained until five to seven hours after the administration. It differs from quinine in producing antipyresis of shorter duration. Its influence may extend over twenty-four hours. Therefore, from its transient action, the attack in some cases may only be retracted. He does not regard the sulphate of quinine as a specific in the true sense of the word in malaria, for it does not act as an antiseptic, but as an antipyretic. The other antithermics, given in convenient doses, and at the proper times, also act in the same manner as quinine.

NERVOUS ASTHMA.

Dr. B. Schuermayer (*Medicinische Neuigkeiten*, No. 1, 1893) recommends in nervous asthma the use of Lebert's pills, containing arsenic, quinine and atropine for they will act when all other preparations fail. They have often the disadvantage that the atropine is not well tolerated and causes terrific dryness of the throat. The iodide of soda is also praised but it alone soon loses its action. If introduced into Lebert's formula it acts, with all the force of atropine and without its disadvantages. The two formulas are as follows:

℞ Atropine sulphate.....3 cgms (1/24gr)
Arsenious acid .....6 cgms (1 gr)
Quinine muriate..... .....4 gms (3j)
Extr. gentian .....4 gms (3i)
Sufficient for sixty pills. One to four pills per diem.

℞ Iodide of soda.....¼ gms (grs. xlv-3j)
Arsenious acid.....6 cgms (1 gr)
Muriate of quinine.....4 gms (3j)
Extract gentian.....3 gms (grs. xlv)
Althæa root.....5 dgms (grs. vijss)
Sufficient for sixty pills. One to six per diem. Three are a moderate dose though it may be increased.

DYSPEPTIC VOMITING IN CHILDREN.

Dr. Tordeus (*Il Raccoglitore Medico*, No. 1, 1893) speaks highly of the following mixture in the dyspeptic vomiting of children:

℞ Pure creasote.....2 4 gtts
Distilled water.....35 gms (3j. 3j)
Syrup of orange peel.....15 gms (3iv)
A teaspoonful every two hours.

CONVALLARIA MAJALIS IN HEART AFFECTIONS.

Dr. Constantin (*Il Raccoglitore Medico*, No. 1, 1893) has employed this drug for a long series of years, in diseases of the heart and claims to have obtained excellent results.

It is a tonic to the myocardium and its influence is felt, little by little, so that it reaches its highest point in ten to twelve days, after beginning its administration. Not all its preparations are equally efficacious. Convallarine, convallamarine and the alcoholic extract are absolutely to be rejected as they yield but uncertain results. The watery extract, on the contrary, seems to him to be capable of giving good results. It is constant in its effects, simple in its preparation, two chief reasons for its suggestions in practice. He usually prescribes the following:

Thymol.....1 gm (grs. xv)
Infuse for five minutes in water 200 gms (3jvss)
Then add—
Watery extract of convallaria 10 gms (3ijss)
Syrup of orange peel.....90 gms (3iij)
To be taken in doses of fifty grams (an ounce and a half a day) for six consecutive days.

SWEATY FEET.

Prof. Kaposi (*Medicinische Neuigkeiten*, No. 32, 1893) recommends, in the treatment of sweaty feet, the following:

℞ Naphthol.....5 gms (3j ¼)
Glycerine.....10 gms (3ijss)
Alcohol.....100 gms (3iijss)

Wash the feet morning and evening with this mixture and then dust with the following powder:

Powdered naphthol.....2 gms (grs. xxx)
Powdered starch.....180 gms (3vj)

Every morning one may dust into the shoes the following powder:

℞ Powdered talc.....40 gms (3jss)
Subnitrate of bismuth.....45 gms (3jss)
Permanganate of potash..... 3 gms (grs. xlv)
Salicylate of soda..... 2 gms (grs. xxx)

PSORIASIS.

In the *Medicinische Neuigkeiten*, No. 32, 1893, the following is recommended in psoriasis:

Chrysophanic Acid.....10 gms. (3ijss)
Chloroform.....90 gms. (3iij)

To be mixed with a solution of ten grams (two-and-a half drachms) of gutta percha, in ninety grams (three ounces) of chloroform.

WHOOPING COUGH.

Dr. J. Roca (*Arcivos de Gineclogia e. Pediatria*, No. 36, 1893) advises the following preparation, in the treatment of whooping cough:

Distilled Eucalyptus Water.....120 gms. (3iv.)
Cherry Laurel Water..... 3 " (gtts. xiv.)
Hydrate of Chloral..... 2 " (grs. xxx.)
Syrup of Belladonna..... 25 " (3v.)
Syrup of Codeine..... 15 " (3iv.)

A teaspoonful every three hours.
The patient should remain in the house, and the air disinfected with a 2: 100 solution of carbolic acid.

CHRONIC DYSPEPSIA IN INFANTS.

Dr J. Roca (*Archivos de Ginecologia e Pedriatria*, No. 36, 1893) states that in such cases the object to be gained is an increase in the acidity of the stomach, by means of either hydrochloric or lactic acid. He employs the following formula:

Hydrochloric or Lactic Acid..... 2 gms. (gtts. xxx.)
Water..... 95 " (3iij.)
Syrup..... 65 " (3ijss.)

A teaspoonful twenty minutes after nursing.

Hydrochloric Acid,
Lactic acid..... āā 1 gm. (gtts. xv.)
Water..... 98 " (3iij.)
Syrup..... 75 " (3ijss.)

Dose, the same as the proceeding formula.

If there are positive signs of dilatation of the stomach, washing out the stomach with boiled water is indicated. Even without dilatation it will give good results, especially before administering the acid.

SENILE INFILTRATIONS OF THE CORNEA.

Dr. Bimbacker (*Hospitals Tidende*, No. 20, 1893) communicates two cases of infiltration of the cornea, in elderly patients, which condition is sometimes met with in old subjects. It takes place into Bowman's membrane and, therefore, is covered with epithelium. After cocainization the supervening epithelial layer is removed by means of a camel's hair brush. A slight quantity of a five-per-cent solution of hydrochloric acid is then applied to the infiltration which, being the phosphate of lime disappears. Any remaining acid is neutralized with a solution of soda. In these cases the reaction is unimportant, and the slight obscuration of vision, which may follow vanishes in the course of a few months.

DYSENTERY AND DIARRHŒA.

Dr. Gelpke (*Archivos de Ginecologia Pediatria*, No. 55, 1893) recommends, in dysentery and diarrhœa of whatever origin, the following formula:

Pomegranate Bark,
Simaruba Bark,..... āā, 5gms. (3j¼).
Macerate in for twenty hours in,
White brandy, ... 375gms. (3xij).

Six to eight teaspoonful in twenty four hours. In children a teaspoonful.

This formula he has found to be an absolutely certain remedy, in the treatment of dysentery and diarrhœa of any origin. Dysentery will yield in four to eight days, even in the most rebellious cases. It is of especial service in infantile and summer diarrhœas.

A DELICATE TEST FOR ALBUMEN IN THE URINE.

Dr. F. Spiegler (*Giornale Speciale di Farmacia*, No. 12, 1893) recommends the following reagent, in testing for albumen, in the urine:

℞ Distilled Water,.....200gms. (3vjss).
Sublimate,.....8gms. (ij).
Tartaric Acid, ...4gms. (3j).
Cane Sugar.....20gms. (3v).

Some of the reagent is poured into a test tube and the urine is added, little by little, after previously being filtered and acidulated, taking care that the two fluids do not mix. If it contain albumen, there appears at the point of contact, a white precipitate at the zone of separation. This reagent will detect one part of albumen in one hundred and fifty parts of urine.

In all the affairs of life, social as well as political, courtesies of a small and trivial character are the ones which strike deepest to the grateful and appreciative heart. —*Henry Clay.*

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SATURDAY, MARC 3, 1894.

EDITORIAL.

TUBERCULIN AND ITS VALUE IN DIAGNOSING TUBERCULOSIS IN CATTLE.

Although the use of tuberculin is gaining favor among certain physicians in the treatment of tuberculosis, the best use to which this bacterial product is being put appears to be in the diagnosis of tuberculosis in cattle. The ravages of tuberculosis in the human species, its unquestioned contagiousness and the identity of human and bovine tuberculosis, all conspire to a more careful inquiry into the existence of this disease in cattle. Although rapid advances are being made in the treatment of tuberculosis, the only wise and ultimately satisfactory course to be taken in the line of eliminating the disease, is to cut off, as far as possible, the channels through which infection come.

Much stress has already been laid on the isolations and sanitary methods to be followed in caring for tuberculous patients in order that they may not infect others. The growing sentiment in this direction gives hope that the time is near at hand when there will be little danger of the spread of the disease from patients to family or attendants.

The next most serious channel of infection is believed by many sanitarians to be through the use of milk from tuberculous cows, and the meat from tuberculous cattle. As Americans cook their meat more thoroughly than most Europeans, the danger from this source does not appear to be so great for us as some of the European investigators have thought. There is, however, much difference of opinion on this subject.

In the danger attending the use of milk from tuberculous cows there is less opposition. It was demonstrated some years ago that *tubercle bacilli* could pass into the milk, and therewith the scientific proof of the possibility of infection through the use of milk was furnished. Numerous experiments have been made with the milk from tuberculous cows to determine under what circumstances the milk is to be considered dangerous. From these experiments the conclusion has been reached by many in-

vestigators that the milk of cows affected with udder tuberculosis must be considered infectious, since it contains almost invariably—some say always—tubercle bacilli. It has furthermore been clearly shown by a number of illustrations that this milk of tuberculous cows, not suffering from udder indurations, was infected with tubercle bacilli. Thus Bang* found the milk infections in nine out of sixty-three cows without udder disease. Although other investigations could be cited the facts stated are sufficient to call attention to the importance of knowing that the cows from which the milk is obtained are not tubercular.

The discovery of tubercle bacilli in milk, while a possible task, is a very difficult one. The diagnosing of tuberculosis in cows by means of inoculating guinea-pigs, or rabbits with the milk from the suspected animals, has proven to be a very long and often unsatisfactory proceedure. It is also, a well-recognized fact among veterinarians that cows may be sufficiently diseased to render their milk dangerous without exhibiting any physical signs or symptoms by which the disease could be detected. So insidious is this disease in cattle that it is usually well established before the health of the animal is appreciably affected. This renders a test more delicate than heretofore known, imperative, if the herds which furnish our milk supply are to be freed from tuberculous cows. It is in these cases that *tuberculin* is rendering so much service.

The value of tuberculin in diagnosing this disease, can be better understood by referring to actual tests.† M'Fadyean found it satisfactory in thirty-one out of fifty tuberculous (determined by post-mortem examinations) cattle, and in a later‡ test of twenth-three animals, all in an excellent condition, but one thirteen years-old cow, all were found to be tuberculous. Eber § reports positive results in 84.5 per cent. of a large number tested. M'Fadyean adds: "That taking full account of its imperfections, tuberculin is the most valuable means of diagnosis in tuberculosis that we possess. * * * It is probable that by using the tuberculin test twice, with an interval of some days between the injections, the proportion of errors in diagnosis would be very small." These and similar results obtained by other investigators are gratifying, as in the great majority of these cases the disease could not have been diagnosed ante-mortem without its aid. The thorough inspections of farm herds with this test would soon enable the owners to weed out the diseased animals and eliminate much of the danger from this disease to the coming generations, thus conferring a blessing upon the future herds of cattle as well as upon the consumers of the milk.

In recognizing the great importance of making an early diagnosis, the questions are often asked by interested parties, Where can I get the tuberculin? How can the test be made?

It may not be known generally, but it is a fortunate fact, that *Koch tuberculin* can be purchased in New York. It is somewhat expensive, however, although the preparations of it would be comparatively inexpensive if a large quantity could be used.

Tuberculin is made from cultures of the tubercle bacillus, and consists of a substance elaborated by the growth of these bacteria. The danger attending the handling of this germ and the consequent preparation of tuberculin by inexperienced bacteriologists or chemists, precludes the practicability of the home preparation of tuberculin, excepting the city or state authorities employ a man for this purpose

*Tedskrift of Veterinare, 1891. Heft, 5.

† *Journal of Comparative Pathology and Therapeutics*, Vol. VI. 1893, p. 120.

‡ Ibid. Vol. VI, (1893) p. 314.

§ Deutsch Zeitchrift f Thiermedicin Bd. XVIII (1892) p. 321.

and provide him with the necessary apparatus. It is hoped, that the Boards of Health will soon provide a laboratory or laboratories where tuberculin can be secured at a slight expense. It is not improbable that the growing demand for this article will soon become sufficiently great to warrant the undertaking of its preparation as a private enterprise. As the strength of each separately prepared lot of tuberculin should be *thoroughly tested* before it is used in diagnosing the disease in questionable animals, it is hoped that the health authorities will supervise its production, that every dram of the substance that goes upon the market or that is used by state inspectors may be efficient. The answer to the first query is, that, at present, the tuberculin can be purchased the same as other medicine.

The method of applying the test is quite simple. The desired quantity (determined by the strength of the tuberculin) is injected beneath the skin of the animal. If the animal has tuberculosis, no matter how slightly affected, the temperature rises from one to five degrees within six to twelve hours. The subject, over which there is much discussion at present, is the cause of error in the temperature reaction. M'Fadyean had nineteen tuberculous animals out of fifty tested, fail to give the reaction, and five others that gave the temperature reaction were found upon post-mortem examination to be tuberculous. He took the temperature of 103° F. as indicating a reactoin, however, which seems to be somewhat arbitrary and it may explain some of the discrepancies in his experiment. Physiologists have found that the temperature of animals varies in the same individual from 1 to 3° F. during the twenty-four hours. In making the test therefore, the temperature of the animals should be taken as often as every two hours for at least twelve hours before the injection and as often after the injection of the tuberculin (after four to six hours) for twelve to eighteen hours. Should the maximum temperature after the injection be higher than the maximum temperature before it, the excess could be considered as a reaction. In M'Fadyean's (l. c.) list of twenty-three animals, all tubercular, the maximum reaction was 4.4° F. over the temperature of the animal before the treatment. The elevation was detected in some animals in four hours after the injection and in others not until twelve hours had elapsed.

In view of the great danger to mankind of tubercular milk, the benefit that will assuredly come to cattle owners by eliminating this disease and all its predispositions from their herds, and the most comforting of all facts that the disease may be detected in its incipient stage by the aid of tuberculin, the hearty coöperation of all men concerned in the elimination of this disease, is most earnestly commended. In this way the good that will come to the human race through Koch's discovery may eventually become greater than it was hoped when tuberculin promised to be a specific. The most important work for sanitarians to accomplish is to *cut off the known channels of infection*, and tuberculosis in cattle is a menace to the health of the people.

"Made an awful mistake at the Gotrox's reception. Stepped up to one of the guests, and told him to order me a horse and carriage." "Did he do it?" "No. He called me an ass."—*Indianapolis Journal.*

Rheumatic Fever.

℞ Tinct. Aconite Root..... ½ drm
Liq. Tong. Sal..... 3 ozs
Glycerine..... 1½ ozs
Ess. Pepsine..... 1½ ozs
M. Sig.: Tablespoonful every two hours.

Myalgia.

℞ Salophen..... 1 drm
Liq. Tong. Sal..... 3 ozs
Glycerine..... 1½ ozs
Spts. Frumenti..... 1½ ozs
M. Sig.: Tablespoonful every four hours.

ABSTRACTS.

THE CAUSES OF SHOULDER PRESENTATION.*

DR. SIGMAR STARK, CINCINNATI.

The author cited two cases of shoulder presentation in the same patient, the first proving uneventful owing to the prematurity of the child, but the second labor was attended with all the difficulty of this malposition. This was terminated by the delivery of a large child which could not be resuscitated.

Among the factors given as the cause of shoulder presentation, is the doctrine of Hippocrates and Aristotle which held sway for many years, that the fœtus sat upright with its back toward the spine of its mother until the seventh month, when it was either suddenly or very gradually rotated so as to assume the opposite position. Playfair considers a number of conditions as predisposing thereto, among them, prematurity of foetus; excess of liquor amnii; undue obliquity of the uterus; low attachment of placenta; irregularity in the shape of the uterine cavity. More common in multipara than in primipara; accidental causes exert most influence, as falls, or undue pressure exerted on the abdomen by badly fitting or tight stays.

Cazeaux and Tarnier add distortions of the superior strait to the above list. Flanging ilii are considered by some as predisposing factors, likewise the wrapping of the funis about the neck of the child, thereby interferring with the descent of the head. Shoulder presentation is also apt to occur in the second born in the case of twins, and is explained by the laxity of the uterine walls which is apt to exist under such circumstances.

I examined this patient twice with the pelvimeter and found the pelvic measurements normal. After version had been performed in the second confinement, the child, though an exceptionally large one, passed through the parturient canal and pelvis very readily, proving that there was no reduction in the size of the pelvic diameter.

I had hoped that the primary deformity of the uterus upon which Wigand and Danyan lay such stress would receive more consideration in the discussion. This observation has received support from such men as Siebold, Naegele, Schroeder and others. Cazeaux and Tarnier are skeptical on this point, however. Subsequent examination of the case presented failed to reveal any evidence of such condition.

*Abstract of a paper read before the Obstetrical Society of Cincinnati.

DISCUSSION.

DR. TAYLOR: I think where the malpositions recur in the same patient, it is almost a certain indication of malformation. And George Engleman, who has written more than any other American on prolapsus of the umbilical cord, traces that to malpositions, and that is almost equivalent to saying there is malposition otherwise, because if the head is all right the cord is not likely to be prolapsed, and so I believe deformity at the brim is more likely to be the cause. The others are undoubtedly true causes, as where there is hydrops amnii, or the presence of twins, there is likely to be malposition. I can recall three cases of shoulder presentation of the second child in cases of twins.

DR. STANTON: I have nothing to say upon this subject that will throw any light upon it. Dr. Stark has gone over the reasons now generally given for this presentation. I think, however, all obstetrical writers refer to the fact that transverse presentations are very often associated with pelvic deformities. The other conditions that favor shoulder or trunk presentations the doctor has referred to. One especially is the great enlargement of the uterus from hydrops amnii, which permits the child to lie in a transverse rather than an upright position. The reason for a frequent association of transverse presentations with pelvic deformities I am not able to explain, but I suppose one reason is the greater obliquity of the brim and the greater difficulty for the head to find entrance to the pelvis, giving lodgment to the shoulders. Also, in these women there are usually other deformities; they are short in stature and their abdomens are short. At least, it has been my experience; so far as I have

observed, cases of pelvic deformity usually occcur in persons of very short stature, whose abdomens are short but enlarged transversely. At the last meeting of this society which I attended, I reported a case of induced labor in a woman, who had had several children. I have referred to this case before and will call it to your minds now. The patient was a woman who had had eight children, all of which had presented by the shoulder except one. Seven of them where deliveries between six and a half and seven months.

DR. PALMER: I, too, cannot throw any light upon this question, but I can refer to my own immediate experience. I have no doubt all the conditions assigned in the causation of this trouble of parturition, exist, as mentioned by the different authorities, but, looking over my past experience, I am pretty well convinced that the pelvic deformity, mentioned by the last speaker, is the cause of most cases. In former years I had considerable obstetrical practice. The patients were mostly of German ancestry. I am pretty certain almost all, if not all, the shoulder presentations occurred in German woman who had a narrowing at the conjugate of the pelvic brim, from what I regarded at the time as the rachitic pelvis. It is easy to understand how a contraction at the pelvic brim, in its antero-posterior diameter, may obstruct a descent of the fœtal head into the pelvic cavity. We know there is a tendency for the head to fall into the pelvic cavity in primi-parous women because of the rigid condition of the abdominal walls, if the pelvis is of normal dimensions, when ordinarily in multiparous women it does not do so, because these walls are relaxed. A rachitic malformed pelvis prevents the normal descent of the presenting head, and the adjoining shoulder is forced down and made to present.

A ZWANK'S PESSARY IMPACTED FOR NINE YEARS AND A HALF, CAUSING RECTO-VAGINAL FISTULA.

Dr. Ernest A. G. Steele reports a case of a woman, æt. 45, who applied at the Cottage Hospital, Plaistow, to have an "instrument" removed from the vagina. She said that ten years previously she had the instrument supplied by the Truss Society for a "falling of the womb." She never went to the Truss Society again, but six months afterwards a friend removed the instrument and replaced it, and it had never been touched since. For five years she has had pain and discharge, and during the last twelve months fæces have occasionally passed per vaginam. On examination, under an anæsthetic, the instrument was found to be a Zwank's metal pessary, which was firmly impacted in the vagina and the handles of which had cut their way into the rectum about one inch above the anus. The pessary was removed with some difficulty and the vagina was irrigated, when it was found that the fistula was about an inch in length. The edges of the fistula, which were much indurated, were pared and brought together with silk sutures. Three weeks afterward the fistula had healed except at its upper part.—*The Lancet*, 1893, p. 1059.

A CASE OF TRANSPOSED VISCERA.

Dr. Frederic C. Coley reports a case of a boy, 15 years of age, who had frequently suffered from bronchitis, but when free from an attack of that kind had not complained of any shortness of breath on exertion. On examination the heart's impulse was found to be an inch below, and half an inch internal to the right nipple. The area of heart dullness was normal in extent, but transferred to the right side of the sternum. The liver dullness was absent from its usual position, but there was a corresponding dullness on the left side. The patient was unaware of the displacement of the heart until I pointed it out to him. He had suffered from nystagmus from infancy, and nyctalopia had long been complained of, *i. e.*, his sight was perfect in broad daylight, but he was almost blind in twilight or ordinary artificial light. He was rather small for his age, and there was no sign of puberty. He seemed fairly intelligent, but was said to be somewhat backward at school, though not more than was accounted for by his frequent absences on account of attacks of bronchitis.—*The Lancet*, '93, p. 1059.

SOCIETY REPORTS.

THE LOUISVILLE CLINICAL SOCIETY.

January 2, 1894.

[Stenographically Reported by C. C. Mapes, M. D.]

PEDICULATED UTERINE FIBROID.

DR. W. H. WATHEN: This tumor is a pediculated uterine fibroid, twenty pounds in weight, which was attached to the fundus of the womb. The woman had suffered with the tumor for fifteen years; it gradually increased in size, and caused serious local disturbances; it had increased more rapidly during the last two years, and was causing so much pain from pressure, loss of flesh, etc., that she insisted upon having it removed. The tumor did not appear to be firmly connected with the uterus, and was diagnosticated as either an ovarian fibroid, or a pediculated fibroid of the uterus. Her urine was examined by the interne at the infirmary and pronounced normal, with the exception of the specific gravity being 1.030. It was examined at night and probably the examination was not reliable. The urine is always examined before I do a laparotomy. The examination is usually made by my chief assistant, Dr. Louis Frank. If there is any trouble with the kidneys I invariably ask the anæsthetist to give chloroform, believing it less injurious in its action upon the kidneys than ether. But if the kidneys are normal I leave the matter entirely with the anæsthetist, and he administers which ever he prefers. In this instance he began the anæsthesia with chloroform, but shortly afterward changed to ether, so that probably five-sixths of the time the patient was under the influence of the anæsthetic, it was by ether. When the abdomen was opened I observed that the tumor was a pediculated uterine fibroid. The omental adhesions, as can be readily seen, were very extensive, and I have never seen omental adhesions so tough. A large portion of the omentum was removed. There was nothing of special interest during the operation, with the exception that just after the adhesions were separated, Dr. Frank with his hand on the abdomen felt the aorta beating very rapidly, and said the woman's pulse was 130. It was normal before the operation. The operation was quickly completed. I examined her twenty minutes afterward and the pulse was 74. I saw her again at 5.30 in the afternoon, two hours after the operation, and at eight o'clock in the evening—pulse 80. She had passed some urine without catheterization. I saw her no more until eight o'clock the next morning, when her temperature was 102° F., pulse 120, urine scanty, passing about an ounce at a time every two hours. There was nothing in the operation that could induce such a condition. I did not suspect trouble with the kidneys, and thought possibly it might be one of those cases with an idiosyncrasy to the toxic effect of iodoform, as a great deal was sprinkled over the wound, though but little could have gotten into it. There was considerable oozing, and a drainage tube was used for seven hours. The iodoform was all removed, but when I returned at noon there was no abatement of the fever, and the pulse was more rapid. The quantity of urine gradually decreased, pulse a little more rapid and during the night ranged from 130 to 140, and the temperature 101° to 103° F. The next morning pulse still 140, urine decreasing in quantity, and after nine o'clock, no urine was passed and there was none in the bladder. There was but little change in the pulse until five o'clock in the afternoon, when it went up to 150 and then varied irregularly from 160 down to 135. She was unconscious until seven o'clock, when the pulse became imperceptible; she passed into a comatose condition about eight o'clock, dying two hours later. She had no convulsions.

There was not a symptom of sepsis; the gas passed freely and the abdomen was flat. The bandage had to be tightened several times, and when she died the abdomen was flatter than immediately after the operation. There was no iodoform poisoning, and nothing to account for the condition except the kidneys. I had the urine examined before her death by Dr. Frank, and append his report:

"*Mrs. D.—urinalysis.*

Amount for 24 hours, not stated.
Specific gravity, 1.030.
Reaction, acid.
Color, reddish brown.
Albumen, ⅛ by volume.
Sugar, none.
Urea, two per cent.
Uric acid and urates, abundant,
Blood, few corpuscles seen in some fields.
Pus cells, very few.
Epithelia, bladder abundant, few vaginal.
Casts, fatty, finely granular, hyaline."

You will observe that the specific gravity was still 1.030. I am convinced that the first

examination was imperfect, and that the woman had, because of pressure of the tumor upon the kidneys, chronic nephritis, and that the ether had acted as an irritant and had brought about a suppression of urine, probably by causing acute hyperæmia.

I report this case because there are not many such cases reported where death has resulted from either chloroform or ether—more frequently of course from ether, although there are some cases reportcd of death caused from suppression of urine from chloroform. I believe that there are more deaths from the effects of ether upon the kidneys than have been reported. Some operators may not feel that such cases are worth reporting; some may not have observed carefully to discover what the trouble was; and some through carelessness may not care anything about reporting them. I make this report to emphasize the significance of carefully examining the urine in all patients where we are going to give ether, and particularly so in abdominal surgery where there is a large cystic tumor, or hard tumor that by pressure upon the kidneys may have caused nephritis. Relatively there are more deaths from ether following operations for fibroid or solid tumors. I have the urine examined in every case to be operated upon, even for curetting the uterus or for a vaginal operation, before the anæsthetic is given, but I will not give ether again until the urine has been examined by a *thoroughly* competent person. While I might have no trouble in many cases, I believe our patients are entitled to this protection.

DISCUSSION

DR. J. W. IRWIN: The case reported by Dr. Wathen is a very remarkable one. I do not care to have anything to say in regard to the surgery or surgical proceedure, but if this was a case of chronic nephritis as the Doctor says, it is very strange indeed that some evidence of nephritis was not present prior to the operation. The specific gravity of the urine following the operation would not correspond in my judgment to a case of chronic nephritis, and neither would hyaline casts, and as there had been no convulsions and no conditions leading to a semi-comatose state, it would be very hard to understand how chronic nephritis could have been in existence, that terminated in death so suddenly after the administration of ether. I do not quite understand how pressure of this tumor upon the kidneys, protected as they are, could have brought about the condition as stated. It is true that tumors may have some influence bringing on disease of the kidneys, but I do not think it is due to the pressure of the tumor. I cannot conceive how a uterine tumor like the one exhibited, could press upon the kidneys, especially a tumor connected with a movable organ like the uterus. The very fact that this patient lived after the operation without going into a comatose condition until she was moribund, and the further fact that examination of the urine showed the specific gravity to be 1.030, with hyaline casts—anyone competent or not might be able to take the specific gravity of urine—leaves this in my mind an open question as to whether chronic nephritis ever existed, or, indeed, any form of nephritis, prior to the operation. It seems to me that the condition which ended in death must have been due to the operation, either to the ether or shock; or it was due to some disturbance produced in the nervous system that brought about the fatal result. The imperfect report of the case hardly admits of discussion. The last urine examined by the chemist seems to throw no light upon the nature of the trouble, and where or when it was obtained from the patient, I do not understand, as "No urine was passed (for thirteen hours before her death) after nine o'clock (A. M.) and there was none in the bladder." It may have been a case of acute nephritis, but this is merely conjecture.

DR. J. A. OUCHTERLONY: The report of the case is defective in one respect, namely, that it does not state what was the character of the casts. A great deal depends upon that. If the casts were of a character that would indicate chronic nephritis, of course, it alters the case. Simple hyperæmia of the kidney does not give rise to a temperature of 103° F.

DR. W. H. WATHEN; The report by Dr. Frank, plainly states, "Fatty, finely granular, hyaline casts." It is usual in cases that have died from ether, where the ether has acted as an irritant upon the kidneys, that there have been no convulsions, and the patients have gone within a few hours of death before entering into a comatose condition. This is true in nearly every case reported. I suggested that probably this patient had acute hyperæmia of the kidneys, the result of ether acting upon either healthy or previously diseased kidneys. There are two forms of renal hyperæmia, one active the other passive. In the active form the arterioles are dilated; in the passive form there is venous dilatation. In the passive form there will, of course, be no fever, but in the active form you may have a temperature ranging from normal to 103° F., with the character of pulse that I have described, and with the same condition, going into coma and death. This is the history of acute hyperæmia of the kidneys in many cases. Dr. Frank's statement, which I file as a part of this report, would indicate that there had been previous trouble in the kidneys; further, that this patient had hyperæmia of the kidneys, because there were blood casts, and other characteristic condi-

tions of hyperæmia. There is one thing certain, the kidneys caused the trouble, and there was no surgical shock after the operation. The pulse went down to 74, and remained under 85 for ten hours after operation, then rose progressively until death. The temperature ranging from 101° F. to 103° F. The kidneys are not protected as Dr. Irwin suggests, from pressure, but may be badly injured by the pressure of a fibroid tumor of the uterus, or any solid, or even cystic tumor in the abdominal cavity.

TRACHEOTOMY FOR REMOVAL OF A BUTTON.

DR. W. O. ROBERTS: One week ago last Wednesday I operated upon a case that was referred to me by Dr. Ray. A child thirteen years of age, the Thursday preceding, had a button between her teeth whistling through it, when by some means it was sucked into the throat, and passed down into the air passages. She was brought to the city the following Tuesday. Dr. Ray made an examination and when she would cough the button would come up into the larynx, sometimes almost entirely shutting off breathing. The button could be plainly seen in the larynx, but could not be grasped. The case was referred to me, and I operated at the Norton Infirmary. Drs. McMurtry, Ray and a number of others being present. Just as the child was going under chloroform, she had a coughing spell, then it seemed to me she had ceased breathing. I made a free opening in the trachea, dividing about four rings, then she coughed a number of times and the trachea seemed to be perfectly free. I opened the wound well and looked up into the larynx, and there was the button which was easily and quickly removed by grasping with forceps. I then closed the wound by passing a suture through the integument and tissues down to the trachea, bringing them together excepting a small point at the lower angle, applying the usual dressing. Absolutely no trouble followed the operation, and on Friday afternoon I removed the sutures; the wound seemed to have perfectly healed, and she went home feeling comparatively well, the operation having been performed on the preceding Wednesday. I have heard from the patient since, and there has been no trouble whatever. The button, which I exhibit, you will see is about three-quarters of an inch in length by one-quarter inch in width.

DISCUSSION.

DR. L. S. MCMURTRY: The case had one very instructive point that Dr. Roberts has brought out, which will bear emphasizing. There was marked disturbance of the respiration when the button was forced up into the larynx and lodged there. It would have been very easy to have overlooked it.

DR. A. M. VANCE: I would like to ask if treatment by inversion had been used in the case reported before operation?

DR. W. O. ROBERTS: No.

DR. J. A. OUCHTERLONY: The case reminds me of a very interesting historical fact: Stephenson, the father of Railways, on one occasion swallowed a sovereign, and with the mechanical ingenuity for which he was celebrated, it occurred to him that he might bring the force of gravitation to bear upon his case in a favorable manner; so an inclined plane was constructed by which he had himself inverted, and sure enough the weight of the gold piece caused it to come down, and all of a sudden it was expelled. He remarked that when he heard the jingling of the gold piece upon the floor he thought it the "Sweetest sound he had ever listened to." I no not suppose anything of the kind would have been practicable in this case.

DR. L. S. MCMURTRY: This occurs sometimes: I remember operating once in the case of a boy who had gotten half of a shell-bark hickory nut hull in the trachea, which had been there for a month. I did a tracheotomy; the usual coughing occurred when the wind-pipe was opened. The foreign body did not present, and I put in a tracheotomy tube. On the fourth day the foreign body was expelled through the larynx, coughed up in a fit of coughing. In coughing, of course, the tube was thrown out, and then the foreign body was also expelled. On investigating the literature I found a number of cases reported where it was believed that opening the wind-pipe was beneficial in enabling the patient to throw out the foreign body. I would like to inquire what has been the experience of the members in this direction.

DR. WM. CHEATHAM: I believe it is a very bad method to insert the tube in these cases. In doing this you have done away with the safety of the tracheotomy. If the wound is held open with sutures, the chances are very much better for getting the foreign body out. I am positive that the tube is not indicated in cases of foreign body in the trachea.

DR. J. A. OUCHTERLONY: One danger in laryngotomy and tracheotomy occurs to me in connection with this case: Not many years ago a friend of mine was called in to see a patient who suffered from paroxysmal attacks of difficulty in breathing, and this gentleman made a diagnosis of tumor of the larynx, and suggested the propriety of an operation. I explained the matter to the family, and inasmuch as he was in frequent danger of suffocation every day and his sufferings were intense, they consented. I gave the patient chloroform, and my friend made an incision through the cricoid and trachea and proceeded to insert a tube. In doing so

the patient ceased breathing. The operator ceased momentarily, and again proceeded to insert the tube, and with considerable more effort, when the patient ceased breathing for good. When an autopsy was made it was found that the soft structures lining the trachea had not been pierced by the knife, and when the tube was pushed in the membrane was pushed before it effectually shutting off the patient's wind. No tumor was found.

DR. W. O. ROBERTS: I have not much to say in closing the discussion: I want to mention a case that I operated upon some time ago, and possibly may have mentioned to this Society:—A child had gotten a shoe-button down into the wind-pipe, and every effort was made to get it expelled without operation. Inversion was used several times without effect. Operative interference was finally determined upon, and as the child was going under the anæsthetic, in fact had gotten pretty well under its influence, there was a violent paroxysm of coughing, the child becoming perfectly blue in the face. When this condition had passed off anæsthetic was resumed, and after it was thoroughly anæsthetized the trachea was opened and held open for quite a while, the child was inverted slapped on the back, etc., still no foreign body came out. The wound was then stitched open, and no tube or anything else put in. I saw the child the next day twice, and no foreign body had escaped. On the second day after the operation I visited the patient again, and found that the button had been passed by the bowel. I am satisfied that this child coughed up the button and the relaxing effect of chloroform upon the muscles of the larynx allowed it to come out and it was then swallowed.

I think one cause of failure in operations of this kind is due to the fact that the opening in the trachea is not made large enough; that is, the incision is too small for the foreign body to get out. One of the first operations of the kind I ever did was for the removal of a cockle burr. I opened the trachea but the foreign body was not coughed out. I then put in two hooks to hold the wound open; these hooks were what is known as the "double-hook" and fastened around the neck. The following day the child had a violent paroxysm of coughing, strangling for breath and pulled the hooks out. In a very short time it was dead. I made a *post mortem* examination, and found the foreign body, (cockle-burr) in the larynx, completely closing it. I suppose the child was not able to get any air from the opening in the trachea and suffocated. In that case I believe if the opening in the trachea had been sufficiently large, or had been stitched open, the foreign body would have been coughed out. After the result in that case I determined never to use an instrument of any kind or description again in the trachial wound, but passed two sutures through either lip of it, one above and one below, and tie them around the neck so as to have a good free opening. Since then I have done quite a number of these operations and the patients have all gotten well. One was a very remarkable case in a child at Owensboro, Ky., who had swallowed a tin whistle. I made a free opening in the trachea, and tried every way after the opening was made to have the foreign body expelled. I passed a pair of forceps down into the trachea thinking possibly I might grasp it; but failed. On the third or fourth day the child had a paroxysm of coughing, raised up in bed, and the foreign body flew across the room.

Dr. P. Guntermann read the essay of the evening

A CASE OF ERYSIPELAS.

(See page 312)

DISCUSSION

DR. WM. CHEATHAM: I do not agree with the essayist that the diagnosis of erysipelis is always very easily made. I have seen a great many cases, where there was an abcess of the tear sac which had been diagnosed as erysipelas. My experience has been that it is quite common for physicians to make diagnosis of erysipelas in abscess of the tear sac, when there is no erysipelas.

DR. C. G. LUCAS: I remember about two years ago I had a case of erysipelas involving the left forearm and part of the arm, and in the treatment I used gauze saturated with 1 to 500 bichloride of mercury. In addition to that I had read somewhere, that where you have erysipelas, particularly of the extremities, by passing an adhesive plaster upon each edge it might be confined. I tried the plaster in this case and found it succeeded very well. It seems to me that some persons are peculiarly susceptible to erysipelas.

DR. A. M. VANCE: I have had a great many cases of erysipelas to treat, and have found that the use of the alimentary canal as a drain to the general system acts as a valuable aid in keeping down the high temperature, also seeming to aid in the rapid cure of the disease; therefore, I have been in the habit of giving salines with considerable regularity. I have always used whiskey internally, and locally I use glycerine and carbolic acid. This applied often, every day, I have found in most cases to arrest the spread of the inflammation, seemingly to absorb it, and keep it within its bounds. I use a small amount of carbolic acid in glycerine, not more than one part in one-hundred, and apply it on antiseptic gauze. It seems that the affinity gly-

cerine has for water deprives the tissue of fluid, and in that way bleaches them, making it a valuable antiphlogistic locally. I believe if there is a specific for erysipelas, we have it in carbolic acid. I do not think I have ever seen a case of erysipelas die, and I have had a great many. In my experience for the last ten years I have noticed how seldom we see erysipelas following wounds that we make. It is an uncommon thing, I believe now, to have a case of erysipelas in wounds made by the surgeon, while years ago such cases were not in infrequent. This is evidently entirely due to the proper cleansing and preparation of the patient beforehand.

DR. J. M. KRIM: I have a number of cases of erysipelas convalescing now. As far as the antipyretic treatment is concerned, I do not believe it does any good. Like Dr. A. M. Vance I think we can get better results by letting the alimentary canal do the work. The administration of salines in my experience has done the most good of any internal medication. As to local treatment, I believe that carbolic acid is the next thing to a specific, although I have had very good results during the last year or two with a preparation called campho-phenic. It is more soothing than carbolic acid alone. The preparation consists of a combination of carbolic acid and camphor. I use with it an equal proportion of liquid alvoline, so as to prevent the too frequent application. Used in these proportions, and applied with a sponge or with anything soft, application will not be necessary more than once every two hours, but with carbolic acid and water it would be necessary to make more frequent applications. It protects the skin and prevents the itching which is characteristic of erysipelatous conditions. Constitutional treatment I do not think amounts to anything as far as superficial erysipelas is concerned. Where there is a phlegmonous condition, of course that requires constitutional treatment; but salines are always indicated.

I want to refer to a couple of cases where the patients had hay fever, and contracting erysipelas it seemed to destroy that condition which had previously existed. I have observed this in two cases that as soon as erysipelas developed there was a disappearance of the hay fever. One case is just convalescing now. I saw him in the first attack two years ago; he was a periodical sufferer with hay fever and was compelled to leave town. After taking erysipelas he had no further trouble with hay fever, and has another attack of erysipelas from which he is just convalescing. I believe that erysipelas may have some effect upon doing away with hay fever.

DR. J. A. OUCHTERLONY: I am very much gratified having listened to my friend Dr. Guntermann's paper; it is exceedingly practical and to the point, and brings up a number of interesting, practical thoughts. In the first place, as to the classification of the disease. Of course we are all aware that there is hardly any disease which presents itself under more numerous aspects than erysipelas. So much so that one is often tempted to ask whether an individual case really is entitled to be considered as erysipelatous in its nature. The variety alluded to by Dr. Guntermann "Erysipelas Fugax," I can hardly believe to be a genuine erysipelas. This variety is described by older dermatologists as "erythema fugax" which comes suddenly and goes as quickly as it came, and while disappearing and as long as it lasts, is lacking in the chief characteristics of an infectious disease. The cause of erysipelas has been considered to be independent of micro-organisms, but I do not think it is. Most recent observations tend to show that it is due to the streptococcus pyogenes aureus. The fatal termination that is so likely to occur in persons of advanced age is also observed in subjects of a very tender age. That is an important practical point. I do not think that in erysipelas occurring in the first two weeks of life the patient ever gets well. At least that is the general impression, and I am sure in my own practice I have never known of a case of infantile erysipelas occurring during the first two weeks, that terminated in recovery.

As to treatment, I am reminded by the remarks of my friend Dr. Vance of a practice that prevailed many years ago in the Demilt Infirmary, New York, introduced by Dr. Sayre. His rule was in cases of erysipelas of the lower extremities, which was the most common seat of the trouble in the laboring class that constitute the patients of that Infirmary, to make a free incision from the knee down to the ankle, and then to administer drastic purgatives. The rule was to make one long, deep incision, then give the patient a dose of calomel; 10 gr. calomel and 20 gr. jalap. The treatment that I have generally adopted has been identical in principle with the saline treatment mentioned by Dr. Vance. I generally use a simple protective with carbolic acid; benzoinated oxide of zinc ointment is a very serviceable preparation in this affection.

It is said that the micro-organisms of erysipelas are found in greatest abundance in the periphery of the erysipelatous area; that in the center there are comparatively few, but at that point where the disease is extending the streptococci are found in greatest abundance. And I suppose it is for that reason that injections at those points have been made of sulpho-carbonate of zinc and other like substance with a view of destroying the septic

agents and preventing the extension of the disease.

DR. W. H. WATHEN: I would like to inquire if any of the members have had experience in treating a case of delivery at term, or premature, in patients suffering with erysipelas, and if so has there been any puerperal trouble following? The same micro-organisms are said to be found in these two conditions.

DR. J. M. KRIM: Four or five months ago I saw a case of erysipelas which was quite extensive, in a patient at about the fifth month of pregnancy. This patient aborted, but there was no puerperal trouble following. I think the abortion was due, however, to the erysipelatous condition.

DR. W. H. WATHEN: I saw in consultation about two years ago, a case of labor where the woman had a severe attack of facial erysipelas, with rapid pulse and high temperature, which caused premature labor at about the eighth month. The attending physician observed every aseptic and antiseptic precaution known in such cases, and the woman had no puerperal trouble whatever, making a prompt and easy recovery.

DR. P. F. BARBOUR: Several references have been made to the antagonism of different micro-organisms: I noticed in a recent issue of the *Therapeutic Gazette*, a report of the case of a young girl who had gonorrhœa and developed erysipelas of the thigh, when it was observed that the gonorrhœal infection immediately subsided, and there was no return of the trouble.

DR. J. M. KRIM: I recently saw a child about six months old that had a discharge from the vagina. Owing to the *pecularities* of the mother, I said nothing about the character of the discharge, nor did I know at first. On the second day I saw the child again, when the discharge was very charateristic and profuse. On the fourth day erysipelas developed, and an examination of the vagina showed that the discharge had almost entirely ceased. However, I instructed that the parts to be douched and on the following day there was no discharge whatever. I hardly think the erysipelatous attack could have stopped the discharge so quickly, but the erysipelas was certainly very well-marked.

DR. P. GUNTERMANN: I agree with Dr. Cheatham that abscesses of the face, particularly about the eye, and swellings coming on from gum-boils or something like that, are very frequently mistaken for erysipelas.

I do not believe that in all cases purgation is the treatment. I think, however, that it is always well to pay close attention to the bowels and kidneys.

As to erysipelas fugax: I simply inserted the word "fugax" in parenthesis in my paper, and did not intend it as a classification.

I believe that a simple dry application is very much better than any wet application, at any rate that has been my experience. Also in a great many cases I have treated, I never succeeded until I perfectly saturated them with an iron preparation. I used tincture of iron *neutralized*, because it makes a fairly pleasant drink diluted with water.

CASE OF RHEUMATISM WITHOUT HISTORY OF TRAUMATISM OR CONSTITUTIONAL TAINT.

DR. J. W. IRWIN: A lady, twenty-eight years of age, is under my care; she is the mother of three children in a perfect healthy state, with good history, no consumption, no scrofula and no syphilis. Evidence of syphilis were absent in the children, also in the husband and in herself. She was taken with an attack of rheumatism affecting the right knee and the right wrist. Pain was very severe, especially in the knee. There was no history of constitutional disease, neither had she been accustomed to hard work or scrubbing. I was called to see the case after it had been treated ten days. There was a great amount of swelling at the knee joint, surrounding the the entire joint—especially about the patella. On the outer side of the patella, parallel with the joint, pain was very intense. I suspected an abscess had formed, and employed exploratory measures which discovered pus. The abscess was opened and discharged I believe about a pint of pus. It is the first case of the kind I have ever seen without any history of traumatism, or the result of constitutional taint. I would like to know if the Fellows have met with such cases, or if such cases are at all common.

DISCUSSION.

DR. J. M. KRIM: I saw one case some time ago in a man who had gonnorrhœa, both knee joints being affected. One was not very painful and was not opened. The other was intensely painful; an abscess had formed which was opened and about a half pint of pus evacuated. I believe that it was the result of the gonorrhœal trouble. While this condition of swelling, pain, etc. was going on, there was no discharge from the penis, but after he obtained relief from the rheumatism, the discharge came on again from the penis; it was more modified than it had been originally, but still continued.

ACUTE ŒDEMA OF THE LARYNX—INTUBATION.

DR. WM. CHEATHAM: A man, fifty-nine years old, was brought to my clinic the other day during my absence, and was sent around to my office. He suffered very great difficulty in breathing. I was busy at the office, but as

it was an urgent case I saw him at once and found it to be one of acute œdema of the upper part of the larynx and referred the case to Dr. Dugan who was at that time holding his clinic at the College. There was a very large cicatrix of the pharynx which indicated to me that the patient had had syphilis, which proved true. Dr. Dugan did a tracheotomy to relieve the difficult breathing; after the patient recovered from the anæsthetic he walked home. The second day afterward I went to see him and found his breathing very difficult, although the trachial wound was opened. I had a small tracheotomy tube with me, and inserted it, but it did not seem to afford any relief. I then decided to do an intubation, but there was some danger in this procedure, on account of the œdema; I feared it might overlap the intubation tube and cover the opening. I took the largest size tube use for intubation purposes, and inserted it without any trouble until it came in contact with the tracheotomy tube, when, of course, it would not go any further. I removed the tracheotomy tube and could then see the intubation tube through the wound in the trachea. As it was a very long tube it extended some distance below the trachial wound. The patients has had no trouble in breathing since; the trachial wound has about closed, no sutures were used. I have had to scarify the œdematous part two or three times, and it is gradually decreasing in size under this scarification, inunctions of mercury and iodide of potassium in progressively increasing doses.

At first I was afraid it was not a case for intubation, on account of the œdema of the throat, fearing as I stated before it might overlap the head of the tube and in that way cut off breathing. But it was perfectly successful.

EHRLICH'S TEST.

DR. J. A. OUCHTERLONY: We are all quite familiar with the fact that the diagnosis of typhoid fever in the early stages is often a matter of difficulty, and for that reason, anything that tends to enable us to make a positive diagnosis in the early stage of the disease, must be of value. In this connection I wish to call attention of the Society to what doubtless you are all familiar with, namely Ehrlich's Test. It never responds save in typhoid fever and in acute miliary tuberculosis, and in some acute inflammations. Acute miliary tuberculosis is usually easy enough of diagnosis. Inflammatory affections are attended with such very characteristic symptoms and physical signs, that there is no difficulty in recognizing them. But typhoid fever is sometimes obscure in its beginnings. Of late I have made use of the Test in a number of cases, and it so happened that they all developed under such circumstances as to make the diagnosis obscure, and but for this test I would have been unable to make a positive diagnosis until several days later.

The test is as follows:

1. Saturated solution of sulphanilic aicd in a solution of 50 c. c. to 1000 c. c.

2. A ½ per cent. solution of sodium nitrite.

A quantity of urine is placed in a test-tube with an equal quantity of a mixture of solution of the sulphanilic acid 40 c. c. and the sodium nitrite 1 c. c. the whole being thoroughly shaken. One cubic centimeter of aqua ammonia is then allowed to flow gradually down the side of the tube forming a colorless zone above the yellow urine, and at the junction of the two a deep, brownish red ring will be seen, if the reaction is present. With normal urine a lighter brownish ring is produced without a shade of red.

The color of the foam of the mixed urine and reagent and the tint they produce when largely diluted with water, are characteristic, being in both cases of a delicate rose-red if the diazo-reaction be present, but if not, brownish yellow.

It may be present before the rash appears, on the sixth day, and has been found as late as the twenty-second.

Chrysarobin in Psoriasis.

The London correspondent of the *Bulletin of Pharmacy* says: "The dirty and unpleasant character of chrysarobin ointment is well known. The extent to which it stains the clothes frequently causes the patient to object to a thorough treatment with this medicament in psoriasis. Dr. Dale James finds that chrysarobin can be applied with more cleanliness by dissolving 1 part chryarobins in 7 parts of chloroform, and stirring about an equal quantity of soft petroleum into the mass. The preparation is applied to the psoriatic area with a brush."

La Grippe.

℞ Benzoate sodium..... ½ oz
Glycerine..... 1 oz
Liq Tong. Sal..... 3 ozs
Aqua Mentha pip ..... 2 ozs
M. Sig.: Tablespoonful every two to four hours.

Diuretic and Rheumatic.

℞ Lithium salicylate..... 2 drms
Liq. Tong. Sal..... 3 ozs
Glycerine..... 1 oz
Aqua Mentha pip..... 2 ozs
M. Sig.: Two teaspoonfuls every two hours.

Malarial Neuralgia.

℞ Acetanylid..... 4 drms
Liq. Tong. Sal..... 8 ozs
M. ft. sol. Sig.: Teaspoonful every four hours.

CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE MEDICAL CHRONICLE OF MANCHESTER ENGLAND.

for February contains an article by Dr. Roger Williams on

Sarcoma of The Breast.

The author shows that the relative liability of the female breast to sarcomatous growths is much below the average for the body in general; 9.4 per cent. of the body neoplasms being sarcomatous, whereas only 3.9 per cent. of female breast neoplasms are of this nature. The feature, that, more than any other, has arrested his attention in connection with this disease is the great rarity of its occurrence, as compared with cancer.

The great majority of mammary sarcomas arise in the immediate vicinity of the small ducts (adeno-sarcomas); only rarely do they originate elsewhere (pure sarcomas). This is the more remarkable when we recollect the great abundance of fibro-adipose tissue that goes to make up the breast, which elsewhere is such a favorite starting-point for these growths. Moreover, the mammary integument enjoys even more complete exception from sarcoma than it does from carcinoma; with the exception of a few rare cases of keloid, the author knows of hardly any other instances of sarcoma thus arising. These facts seem to indicate that the abnormal post-embryonic developmental changes, whence the disease originates, are the outcome of abnormal functional activity. The matrix tissue of the initial proliferative changes usually is the layer of hyaline substance immediately surrounding the epithelial investment of the small ducts, which has been shown to be a myxomatous modification of the adjacent connective tissue, consisting of a network of flattened, branching, nucleated cells, embedded in hyaline stroma. Owing to the intimate relationship thus subsisting between the glandular and connective tissue elements, both are usually involved in sarcomatous neoplasms of this part.

The author believes that the glandular structures met with under these circumstances are of neoplastic origin, rather than the outcome of mechanical distortion of pre-existing structures, from the fact that they have often been found within intra-cystic growths several inches long. Nevertheless, it seems certain that these grandnlar structures do not form an essential element of the disease. The term adeno-sarcoma, given by Billroth to growths thus constituted, is however a good one, and it certainly ought to be retained.

In regard to adeno-sarcomas of the breast, the author's observations would lead him to the conclusion that they are of much commoner occurrence than pure sarcomas, in the proportion of about 80 per cent of the former to 20 per cent. of the latter.

With regard to the treatment, the whole breast, together with the tumor and the overlying skin, should be freely removed in every case at the earliest possible date. Unless the tumor is situated altogether on the anterior aspect of the gland, the fibrous sheath of the pectoral miscle should also be removed with it. Simple enucleation of the tumor must be condemned as an unscientific procedure. After extirpation of the diseased part it is a good practice to wash the wound with a strong solution of chloride of zinc (20 to 40 grains to the ounce). In doing this operation care must be taken to completely remove the axillary mammary processes. When enlarged lymph glands are present the axilla should be cleared, just as is done for cancer.

With regard to the after results, recurrences rarely supervene later than four years after the primary operation. Those, therefore, who survive free from return of the disease after this period may be regarded as cured. Recurrent growths, when operated, should be freely excised as soon as noticed. This practice not only prolongs life, but in many cases, after repeated operations, it has at length resulted in radical cure.

The statistical part of the paper is very full and the social state of the cases which have come under the author's observation is carefully noted, as is also the occurrence of pregnancy and the family history in regard to the occurrence of malignancy in any member of the family. The paper will be continued in the next issue of the journal.

Dr. Frederick Cox reports a "Case of Chronic Tympanic Disease with Marked Irritability to Treatment." The case is distinguished from the general run of such cases by the marked intolerance of medical treatment, and the temporary improvement of hearing power which was produced by an acute purulent tympanitis occurring while under observation.

Dr. Graham Steell reports a "Case of Cirrhosis of the Liver Complicated with Ulcerative Endocarditis."

THE CHICAGO MEDICAL RECORDER

for January contains a paper by Dr. Boerne Bettman, entitled

Subvolution—A New Pterygium Operation.

During the last six years the author has followed the method advised with good results. The underlying principle of the procedure is to prevent readhesion by placing a mucous surface in contact with a raw one. To do this he turns the triangular flap underneath, which action can best be described by the term subvolution (turning under). In order to carry out this rule he performs the operation in the following manner:

The pterygium is gathered up by the two branches of a fine forceps serrated at the ends. A knife is passed underneath it close to the cornea, and the triangular membrane is dissected off toward the apex. A suture with a needle at each end is passed through the

apex. Both needles are inserted from above downward, thus leaving a loop of thread on its outer surface. The needles are now passed through the base from below outward. The points of puncture being the ends of parallel lines drawn from the punctures in the apex and just far enough back so that when the flap is turned upon itself underneath the base, the role will correspond with the corneo scleral margin.

The two ends of the suture are now firmly tied, which induces a condition similar to gumming the flap of an envelope to its body. The under surface of the pterygium is brought in contact almost throughout its entire extent, and adheres. A readhesion to the cornea is prevented by the role of mucous membrane at the corneo scleral margin.

The only seeming drawback to this procedure is the temporary unsightly thickening produced by the folding. This, however, disappears in a few days, and after a week or two flattens and settles down to the niveau of the adjacent parts of the eyeball. It adheres to the sclerotic.

The raw surface of the cornea is covered with scar tissue and regenerated epithelium.

No matter how much the base of the pterygium contracts after dissection from the cornea, sufficient allowance can always be made by stitching the apex more or less forward.

The apex may be cut off, or not, depending entirely upon the degree of thickness. It is hardly necessary to state that the eye is bandaged and cleaned daily with a boric solution, and that the thread is removed after two or three days.

The operation is especially indicated in large pterygia. Even in smaller ones, where the growth contracts considerably after having been separated from the cornea, it is followed often by good results.

In these cases adhesions will form, which will draw the turned flaps over the sclerotic up to the corneo scleral margin.

John A. Wesener, Ph. C. discusses

The Clinical Significance of Peptonuria.

He regards the subject as of the greatest importance, not only from the standpoint of the medical practitioner at lage, but from that of the surgeon, for it is often difficult to diagnose an abscess of any one of the internal organs and the detection of the presence of peptone in the urine goes far to warrant a diagnosis of this kind, its presence usually indicating that suppurative changes are in progress in some part of the system, the diagnostician having carefully excluded all other known causes. The author gives the following tests for peptone:

Tests for Peptone. If the urine contains albumen or mucin, it must first be removed. Albumen is removed as follows: to 50 c. c. of urine, add 10 c. c. of a saturated solution of sodium acetate and then a concentrated solution of ferric chloride, until a deep red color is produced. Potassium hydrate is now added, drop by drop, until neutral, then boil and filter; test a portion of the filtrate for albumen. Apply the acetic acid and potassium ferro cyanide test. If albumen is found, the filtrate must then be treated again with a little sodium acetate and ferric chloride solution, boiled and filtered. This is repeated until the test for albumen given above fails to react. the remaining filtrate, having been allowed to cool is then treated for peptone by adding a few drops of sodium hydrate and two or three drops of cupric sulphate; this gives a purple color if peptone is present and is known as the biuret test. A saturated solution of tannic acid gives a good reaction with peptone, but does not show traces that will be shown by the biuret test, and should any of the iron be left in the filtrate, it will form with tannic acid, the tannate of iron, which would obscure any precipitate formed. The removal of albumen by this method has the advantage of also removing the greater part of the coloring matter from the urine.

Devoto recommends the precipitation of albumen with crystals of ammonium sulphate. This takes more time and, as regards the urine, has no advantage over the method given. If peptone is tested for in the blood or visceral fluids, Devoto's method should be used as the results are more accurate.

Albuminous urine which has decomposed cannot be tested for peptone, as some of the albumen has been converted into peptone, and would give a reaction which would be of no clinical value, even though the albumen has been removed. This also applies to decomposed nonalbuminous urine, since bacteria have an albuminous structure peculiar to themselves which will react unless removed.

Urine containing mucin appreciable with acetic acid must be removed. To 20 c. c. of urine add just enough lead acetate solution to produce a flocculent precipitate, an excess must be avoided; filter and test filtrate for peptone, using the biuret test. A simple method of making a quantitative estimation for peptone is as follows: To 10 c. c. of urine apply the biuret reaction; then dissolve a known quantity of peptone in 10 c. c. of normal urine and apply the biuret test. Repeat the last operation until the colors are identical. Having a known strength of peptone solution for comparison this will give you the amount of peptone in the urine. The author has found this to be satisfactory and simple. Where albumin and mucin are absent the biuret or tannic acid test can be proceeded with without the preliminary steps. The author states that in inflammation and the production of pus from bacterial action, peptone is always present in the urine. The paper includes a brief report of several cases.

Dr. W. K. Jaques discusses

The Operative Treatment of Diphtheritic Laryngeal Stenosis.

He argues that the treatment of diphtheria, operative or otherwise should be:

First, to neutralize the poison, and to confine the disease if possible, to the primary seat of inoculation.

Second, to support the vitality of the patient, and prevent the ajoining respiratory

passages from becoming susceptible. That operation and medication should be selected which will best admit of carrying out these principles.

In malignant diphtheria, where the primary seat of inoculation has been in the upper respiratory passages and stenosis is secondary, tracheotomy is the best operation. The reasons for this are:

First, the air enters the respiratory passages below the disease and goes into the lungs pure, making auto-infection less likely.

Second, the pharynx and naso-pharynx can be better cleansed than if an intubation tube is in the throat.

Third, in this class of intubation cases, feeding is very difficult, but in tracheotomy it can be done quite well by passing a catheter through the nose.

Fourth, rest is a most important thing in the treatment of inflammation; and not a small item in favor of tracheotomy is that the diseased parts are at rest.

If intubation is performed upon such a case, even by the most skillful operator, the parts are likely to be lacerated; the tube will cause more or less irritation or coughing; the gasping draws poison-ladened air into the lungs, already made more or less susceptible by the labored respiration, and the condition known as "cut-throat" lung is the result.

A large majority of cases of laryngeal stenosis die from the spreading of the disease downward, and in every case that operation and treatment should be selected which will render this the least likely.

When we have reasons to believe that there is loose membrane in the trachea, tracheotomy is considered by many as safest for the following reasons:

First, during the insertion of the tube in intubation, the membrane may become detached, and be pushed in front of the tube; this danger, however, has been over estimated.

Second, the membrane may become loose, and act as a valve over the end of the tube, allowing the air to enter but not to escape, thus causing the chest to become barrel-shaped.

Stenosis caused by or following scarlet fever is best treated by tracheotomy.

In regard to the tube in tracheotomy, the author prefers the Durham tube on account of its shorter curve and jointed inner tube, which, therefore, has a less tendency to produce ulceration of the posterior wall of the trachea from pressure. The objection to this tube, however, is that it is too large and cumbersome. The author has prevented the backward pressure in the ordinary tubes by putting a rubber diaphragm over the retaining piece and slipping it back as far as the tissues would permit. This grasps the tube firmly, at the same time giving it all the movement required.

Every city should have a diphtheria hospital. This, as well as other contagious diseases, should be placed directly in the care of the health department. Isolation should be demanded, and when people are poor and living in a manner that this is impossible, the sick should be removed to a hospital where they would not be a source of danger to others.

The author concludes his interesting paper with the following brief and convenient summary of the cases suitable for operation:

Intubation.

First. Stenosis, from primary laryngeal diphtheria.
Second. Non-membraneous laryngitis.
Third. All cases under two years of age.
Fourth. Stenosis from measles.
Fifth. All cases in which tracheotomy is refused and intubation permitted.

Tracheotomy.

First. Secondary stenosis in malignant diphtheria.
Second. When there is membrane in the trachea.
Third. Stenosis in scarlet fever.

Dr. F. E. Waxham contributes "A Plea for the Early Climatic Treatment of Pulmonary Tuberculosis." The author urges that cases to receive the greatest benefit from climatic treatment should be sent early while the disease is in its incipiency. These cases must seek a change of climate as a first resort and not as "a last resort" after other methods of treatment have been tried and failed. As soon as the patient shows signs of tuberculosis he should at once be directed where to find almost certain relief. No delay should be sanctioned or encouraged in the vain hope that other lines of treatment may give relief.

There are two classes that should permanently occupy Southwestern Texas, New Mexico, Arizona, Colorado and Utah, and largely constitute the population, those with incipient tuberculosis, and those predisposed to the disease by heredity.

Dr. D. A. K. Steele presents the "Report of a Case of Cerebral Tumor, Diagnosed by Focal Symptoms, with Operation, Successful Removal of the Tumor."

Examination showed motor paralysis and sensory blunting of the right leg; the right patella tendon reflex was much increased; hearing was much reduced in the right ear; there was no choked disc or optic neuritis; none of the orbital muscles were involved. Speech was slow. A diagnosis of cerebral tumor originating in the leg centre of the cortical area of the left hemisphere of the brain and extending downward and forward to the arm and face centres, was made, and operation advised, after specific treatment was tried without avail.

The remaining paper in this issue is "Induration After Lobar Pneumonia," by Dr. Ludwig Hektoen.

Nervous Headache.

℞ Potass. Brom..... 4 drms
Liq. Tong. Sal..... 8 ozs

M. ft. sol. Sig.: Teaspoonful every hour until the desired effect is secured.

PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

MEDICINE.

Oderless Iodoform.

Iodoform it is said can have its disreputable odor successfully masked in the following combination: Iodoform, powdered benzoin, powdered cinchona, and magnesium carbonate, equal parts and a little oil of eucalyptus. The formula is credited to Lucas-Championniere.

Choloform in the Treatment of Tania.

The following has proved useful:

℞ Spts. cholorformi.....5j
Ol Crotonis (Tiglii).....gtts. j
Glycerini.....5j
M. For one dose.

—*Dr. Graesse.*

Apomorphine for Hysteria.

Rossen reports success in cutting short hysterical attacks and in preventing their recurrence by the administration of one-tenth of a grain of apomorphine hypodermically. In the case of a morphine user, the impression was given that the apomorphine was the drug to which she was accustomed; and in consequence the morphine habit was permanently broken up.—*Times and Register.*

Jaundice Due to Simple Obstruction Successfully Treated by Olive Oil.

Dr. Thos. Olive reports two cases in which symptoms, which had persisted for many months under vigorous medical treatment by himself and others, gradually disappeared under the administration of olive oil. He says: "In the treatment of recurrent hepatic colic I do not claim for olive oil that it dissolves the gallstones, nor do I regard the greenish concretions passed per anum by patients thus treated as softened gallstones. Microscopical and chemical examination have shown them to be practically nothing else than inspissated oil. Nevertheless as to its decided influence for good in certain cases of obstructive jaundice, I have no doubt. In such cases our experience at present is in advance of the therapeutical explanation."—*Lancet.*

Reducing the Tonsils.

Dr. Tact De Blois believes that galvanocaustic puncture, while not a perfect method is the best we have at present at our command for reducing the size of enlarged tonsils. The operation is performed under cocaine anæsthesia. The cautery point is pushed about a quarter of an inch into the tonsil avoiding the crypts. The pain is not very severe. Slight inflammation follows and a little sloughing from the burned parts. Diminution of size, estimated at about a quarter, occasionally follows at the end of ten days after the first burning. The igni-puncture should be repeated perhaps three times. About half the cases will show some improvement after the first burning. In about quarter of the cases this treatment will prove so slow or so unsatisfactory that resort will have to be had to tonsilotomy.—*Bost. Med. and Surg. Journal.*

The Action of Permanganate of Potassium in Rendering Morphia Inert.

At a meeting of the Medical and Surgical staff of the West side German Clinic, Forty-second street, New York, Dr. Wm. Moor, one of the physicians to the clinic, recently gave a demonstration on his own person of the efficacy of permanganate of potassium, as an antidote for morphia. Against the earnest protestations of those present, he swallowed 3 grains of sulphate of morphia in solution and immediately afterwards he drank a solution of four grain of permanganate of potassium in four ounces of water. He was carefully watched, but none of the ordinary effects of morphia on the system were observed, and he has since stated that he experienced no ill effect whatever from the poisonous dose taken. He claims that morphia or any of the salts of opium are immediately rendered harmless by contact with the permanganate. The antidote should be administered as promptly as possible after the morphia is taken. Experiments indicate that the permanganate does not control the action of the poison after it is introduced into the general system. Since the demonstration it has been claimed that the honor of discovery is really due to Dr. Wm. Condy, of London.—*Bost. Med. and Surg. Journ.*

Post Mortem Idrosis.

A writer in the *International Medical Magazine*, records the following curious phenomenon in a case of death from angina pectoris. "The face of the corps seemed to be bathed in prespiration, the moisture reproducing itself after being wiped off, in spite of the presence of rigor mortis, and other unmistakable evidences of death. This most extraordinary phenomenon was witnessed by several local physicians, who also viewed the body. The funeral on that account was delayed several hours, until decomposition had fully set in."

Burns.

℞ Cocaine hydrochlorate.....gr. v.
Campho-phenique.....
Olive-oil.....āā ℥ss
M. Rub up the cocaine and campho-phenique and add the olive-oil.

—*Medical Review.*

SURGERY.

Intubation of the Larynx in Private Practice—Results in 78 Cases.

C. M. Whitney, in *Bost. Med. and Surg. Journal*, divided according to age. They were:

	Cases.	Recoveries.
Under 1 year	2	0
One—2 years	12	3
Two—3 years	18	6
Three—5 years	20	5
Five—10 years	26	12
	78	26

This table shows 33 per cent. of recoveries. When there is persistent and increasing retraction of the intercostal, supusternal and super clavicular spaces, no advantage is to be gained by waiting, but intubation should be done at once. The writer mentions some changes he has made in the apparatus and gives careful direction about the details of introducing the tube. A list of the articles of food which may be administered during the wearing of the tube is given. From the fourth to the sixth day the tube should be removed. This is far more difficult than its introduction. An extractor divised by Dr. Nichols, of the Boston City Hospital, is favorably mentioned. Intubation is an operation especially adapted to private practice —always available, can be done early, and is painless and bloodless. It is not advisable when the tonsils are so large that they prevent the necessary manipulation or when the fauces are full of putrid debris and the epiglottis is immovable from the distructive action of the disease.

The Treatment of Influenza.

Dr. Wm. Henry Thayer writing to the *Medical Record* of his treatment of influenza in the epidemics of 1891 and 1892 says: It was treated as we should treat diphtheria, with bichloride of mercury, adopted on the ground of its being a powerful germicide. I treated all my cases that way and with excellent results. In seven attacks it was given in doses of 1-30 gr. every half hour at the outset for several hours, and continued at longer intervals afterward. The effect was always good on the prime disease, and the convalescence usually so tedious, and in lessening the frequency of secondary affections.

The Indications For Bleeding.

Sir. Benjamin Ward Richardson, is rather fond of bleeding, and in his *Aesclepiad* he has published several articles describing his experiences and his successes. In the last issue of this Journal he tries to indicate the moment for bleeding, and the conclusions to which he arrives, are these:

One may bleed—

a. In acute spasmodic seizures, as in spasms of croup, in colic and in augina with symptoms of oppression from distension of the right side of the heart with blood.

b. In acute pain, membranous or spasmodic, as in sudden pleuritic or peritoneal pain, or in pain from passage of a calculus hepatic or renal.

c. In acute congestions of vascular organs, as of the lungs or brain, apoplexies.

d. In cases of sudden shock or strain, as after a fall or a blow, sunstroke or a lightning shock.

e. In some exceptional cases of hemorrhage of an acute kind, unattended by pyrexia.

This, it seems to us makes a rather poor showing for venesection. It means practically, that bleeding is only needed in urœmic convulsions and dangerous apoplexy, for in most of the other conditions morphine, or some heart stimulant would answer as well, if not better.

The fact is, bleeding has gone forever from ordinary therapeutics. This is not because it is useless, but because modern science has devised better things as substitutes. Bleeding was legitimate and effective in its day, and would be useful now if our materia medic had not been so enlarged. We have given it up, not because of a change of fashion, but because we have outgrown it.—*Ed. Medical Reaord.*

ARMY AND NAVY.

U. S. ARMY FROM FEBRUARY 18, 1894, TO FEBRUARY 24, 1894.

The leave of absence on Surgeon's certificate of disability granted Major Edward B. Moseley, Surgeon, U. S. Army, is extended one month on surgeon's certificate of disability.

First Lieutenant Benjamin L. Ten Eyck, Assistant Surgeon, U. S. Army, will report in person to Colonel Joseph C. Baily, Asst. Surg. General, president of the examination as to his fitness for promotion.

U. S. MARINE HOSPITAL SERVICE FOR THE FOUR WEEKS ENDED FEBRUARY 17, 1894.

Murray, R. D., Surgeon; to proceed to Key West, Fla., for special duty, January 26, 1894.

Bailhache, P. H., Surgeon; granted leave of absence for twenty days, February 2, 1894.

Purviance, George, Surgeon; detailed as Chairman Board of Examiners, February, 12, 1894.

Stoner, G. W., Surgeon; detailed as member Board of Examiners, February 12, 1894.

Carter, H. R., Surgeon; to report at Bureau for temporary duty, February 2, 1894; to proceed to Brunswick, Ga., as Quarantine Inspector, February 6, 1894; detailed as recorder Board of Examiners, February 12, 1894.

White, J. H., Passed Assistant Surgeon; granted leave of absence for seven days, February 17, 1894.

Carrington, P. M., Passed Assistant Surgeon; granted leave of absence for thirty days, February 19, 1894.

Bratton, W. D., Passed Assistant Surgeon; granted leave of absence for thirty days, January 20, 1894.

Pettus, W. J., Passed Assistant Surgeon; granted leave of absence for thirty days, January 30, 1894.

Vaughn, G. T., Passed Assistant Surgeon; to report to the Secretary of the Treasury for special duty, January 26, 1894.

Young, G. B., Assistant Surgeon; ordered to examination for promotion, February 14, 1894.

Stimpson, W. G., Assistant Surgeon; ordered to examination for promotion, February 14, 1894.

Brown, W. B., Assistant Surgeon; ordered to examination for promotion, February 14, 1894.

Rosenau, M. J., Assistant Surgeon; granted leave of absence for thirty days, February 26, 1894.

Cofer, L. E., Assistant Surgeon; to proceed to Mobile, Ala., for duty, January 30, 1894.

Eager, J. M., Assistant Surgeon; granted leave of absence for four days, January 30, 1894.

Blue Rupert, Assistant Surgeon; granted leave of absence for eight days, January 26, 1894.

Norman, Seaton, Assistant Surgeon; ordered to examination for promotion, February 14, 1894.

Prochazka, Emil, Assistant Surgeon; to proceed to New York, N. Y., for duty, January 24, 1894; to proceed to Buffalo, N. Y., for temporary duty, February 2, 1894.

NEWS AND MISCELLANY.

Medical Society of the State of Pennsylvania.

COMMITTEE ON SCIENTIFIC BUSINESS.

Dear Doctor:—At its last meeting the Medical Society of the State of Pennsylvania appointed—under the provisions of a by-law proposed at Harrisburg and adopted at Williamsport—a Committee on Scientific Business, "To secure scientific papers and to provide scientific discussions for each annual meeting, and to co-operate with the Committee of Arrangements and Credentials in arranging the programme." The members of this Committee are Drs. Dulles, of Philadelphia; Gorgas, of Harrisburg; LeMoyne, of Pittsburg; Tyson of Philadelphia; and Towler of Marienville. The object of this change in the law is to have a permanent Committee which, becoming familiar with the subject, shall find it easier to secure good scientific work than is possible for a committee that is appointed new every year.

The Committee on Scientific Business is working in conjunction with the Committee of Arrangements, of which Dr. E E. Montgomery is Chairman, and will co-operate with it in arranging the programme.

The committee hopes that each member of the State Society will aid it in attempting to make the meeting of the Society of greater scientific importance than they have been in the past. To this end the Committee will welcome suggestions from any member of the Society and especially, at this time, offers of contributions to the work of the next meeting, at Gettysburg, May 15 to 18. It is desired that there should be as many brief, concise, practical papers as possible, and it is proposed to have a discussion on Tuberculosis, devoting the morning to "Medical Tuberculosis," and the afternoon to "Surgical Tuberculosis"

Any communication from members of the Society in regard to the work of the Committee will be welcome by it.

Members of the Society desiring to read papers, or to take part in the discussion on Tuberculosis will please notify the Chairman of the Committee.

DR. CHARLES W. DULLES,
4101 Walnut Street, Philadelphia.

To Those who Read Medical Society Papers.

We have often seen this notice over doors entering manufacturing places: *Keep out, this means you.* So we write this editorial for the members who took part in the last meeting and for those who will engage in the next, and we add this: *Read it, this means you.*

Time your article beforehand. Boil it down until it can be delivered in fifteen minutes. This rule would have seemed at least two hours for debate in the recent meeting.

Confine yourself to manuscript strictly—interpolations and after remarks are wasteful and exceedingly tiresome.

Be familiar with your piece, one of the best articles of the session lost not a little of its attractiveness because the author was unable to decipher his writing so as to read it in an easy manner.

Be brief, others are anxious to speak as well as you. Enthusiasm is a good thing but when a doctor talks an hour he wearies his audience and cheats his colleagues.

Be sure you have something to say when you talk, then say it concisely, clearly and but once.

In discussions don't repeat the author's paper agreeing in all points; briefly allude to them, and dwell only on something not yet mentioned.

If a doctor reports a very uniquecase, d on't dampen his ardor by always havi ng one just like it. If you habitually do so you will be regarded as an hereditary exaggerator—*South Cal. Practitioner.*